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NATIONAL ASSOCIATION OF SOCIAL WORKERS

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SOCIAL WORK

JOURNAL OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

SOCIAL WORK is a professional journal committed to improving practice and extending knowledge in the field of social welfare. The Editorial Board welcomes manuscripts that yield new insights into established practices, evaluate new techniques and researches, examine current social problems, or bring serious, critical analysis to bear on the problems of the profession itself. The occasional literary piece is gladly received when it concerns issues of significance to social workers.

Opinions expressed in the journal are those of the authors and do not necessarily reflect the official position of the National Association of Social Workers.

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Editor's Page

SOCIAL WORK is still plagued by lack of definition of its scope and role. There is still confusion between social welfare, the goal, and social work, the profession. Since social policy demands definition of field, problems, goals, and function, this journal looks for continuous endeavors from practitioner-readers as well as from NASW commissions toward classification and a more careful use of professional terminology. In a not too distant past two distinguished professional publications, largely devoted to casework, used such different vocabularies, not to say dialects, that overlapping readership was extremely difficult.

Classification is lacking today at all levels. A descriptive classification may be the final and easiest step! For example, *parental inadequacy, broken home, desertion, non-support, cultural isolation, segregated housing, slum area, gang rumbles (warfare), community apathy*, and so on. Etiological classification is particularly difficult because of multiple causality in psychosocial phenomena. For instance, *family friction*, because of religious and cultural difference, economic strain, unresolved Oedipal development, alcoholism with nonsupport and other complications may all be present in one family unit. Several classifications of the more obvious social problems have been attempted but are little recognized by the profession as a whole.

How then is the practitioner who may have more of an aptitude for treatment than for research or social action to involve himself and his agency in the formulation of social policy? Sophonisba Breckinridge, one of the great teachers at the Chicago school, once said that she usually sent a telegram a day supporting or protesting something. Not everyone can be a statesman either, but there is a habit of work which leads into deepening of professional knowledge, namely, that one is always studying something in practice which especially interests him, with the reward that the more

he studies the more it will interest him. Too many years of any professional life are wasted on committees in which the task is never defined or mission accomplished.

So let us give up *one* committee, find out what problem most interests us in our day-to-day practice, work at it, read everything written about it. Let us not hop, skip, and jump through the *Social Service Review*, *Social Casework*, *SOCIAL WORK*, and other publications, reading only what strikes our momentary fancy, but read *all* the papers about our subject. Clarify problems, functions, goals, techniques, and results in such a way that communication for discussion, teaching, reporting to staff, or in a paper is reliable. And it is not unlikely that opportunities will present themselves for influencing social policy based on competent and comprehensible judgments.

While awaiting definitive classification the editors recommend that:

Social work is the profession, not casework or group work. *Social worker* is the accepted term. *He*, not *she*, is the comprehensive pronoun.

Casework, as method, is a constellation of specific knowledge and skills used in the treatment of individuals.

Group work, as method, is a constellation of specific knowledge and skills used for individual, group, and intergroup treatment.

The various forms of *therapy*, whether individual or group, suggest the purpose of change, re-education, and health conservation.

Psychotherapy, whether individual or group, uses psychological means in which verbal communication is characteristic. Various combinations of psychological and social therapies are used in both individual and group treatment.

Another caution to authors: In writing for the journal, please do not use such atrocities as *group casework* or *case group-work* and do not distort established terms in social work, medicine, law, social science, because one likes inventing one's own terms—at least give reasons for the departure.

—GH

BY HOWARD J. PARAD AND GERALD CAPLAN

A Framework for Studying Families in Crisis

WHAT IS FAMILY diagnosis? If we agree that it is more than a listing of individual-centered clinical observations, we immediately encounter many technical problems. For we find ourselves dealing with a complicated field of forces requiring a three-dimensional perspective that involves not only *intrapersonal* but also *interpersonal*

and *suprapersonal* (or "transactional") processes. Recognizing the family's strategic importance in human life, investigators in social work and social psychiatry have shown increasing interest in grappling with these problems. Consequently the development of a multifaceted formulation for describing and classifying the dynamics of family behavior has attracted a good deal of attention in recent professional literature.¹ The purpose of this paper is to outline a the-

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¹ See, for example, "Family Casework in the Interest of Children," report of an interdisciplinary conference, *Social Casework*, single issue, Vol. 39, Nos. 2-3 (February-March 1958); Viola W. Weiss and Russell R. Monroe, M.D., "A Framework for Understanding Family Dynamics," *Social Casework*, Vol. 40, Nos. 1 and 2 (January and February issues, 1959); Gerald Caplan, M.D., ed., *Emotional Disorders of Early Childhood* (New York: Basic Books, 1955), pp. 155-156; Nathan W. Ackerman, *Psychodynamics of the Family* (New York: Basic Books, 1958); John P. Spiegel and Florence R. Kluckhohn, *Integration and Conflict in Family Behavior* (Topeka, Kan.: Group for the Advancement of Psychiatry, 1954). Especially pertinent is a critique of recent literature on this subject by John P. Spiegel and Norman W. Bell, "The Family of the Psychiatric Patient," in the *American Handbook of Psychiatry* (New York: Basic Books, 1959), pp. 114-149.

oretic framework found useful in a study of family functioning in its relationship to mental health. Our report will focus on the mental health implications of the mechanisms which families characteristically use to solve the problems of a crisis situation. Part I will introduce our broad conceptual framework; Part II will demonstrate the use of this framework through a case analysis of a family experiencing a serious crisis situation.

The project from which our observations are taken has served the twin goals of (1) investigating how best to integrate a mental health program within an operating public health unit,² and (2) studying how families cope with selected stress situations (prematurity, congenital abnormality, and tuberculosis) commonly encountered and routinely reported in public health programs. The reconnaissance phase has included exploratory investigations in fifty cases involving these stress categories.

A word should be said about the setting in which this interdisciplinary research operation took place. We were routinely introduced to our study families by the public health nurse with whom we had the dual role of mental health consultant and research collaborator.³ The nurse continued in her ordinary role with the family while we carried on our investigation of the family's perception of and response to the crisis situation.

By design, we used what Bowlby calls a "current" rather than a "retrospective" study approach.⁴ We found that useful information about the crisis could be obtained only by interviewing the family while it was actively engaged in its coping efforts. Retrospective accounts of crisis events were

typically colored by tremendous distortions. Family members were interviewed individually and in groups, often at mealtime or while engaged in household or child care tasks. From time to time, with the family's permission, interviews were tape-recorded for detailed subsequent analysis. Although the interviewing style was informal and unstructured, data were systematically accumulated in terms of the following major categories:

1. Identifying information
2. Dynamic description of individual family members
3. Primary medical stress
4. Attendant and secondary stresses
5. Relationships among family members
6. Relationships with persons outside the family
7. Family activities
8. Relationships between the family and the Family Guidance Center
9. Solution to the problem

The last category, intended as an analysis of the family's adaptive and maladaptive responses to the problem, is based on summary data contained in the other eight categories.

In all but a few experimental cases, every effort was made to keep our therapeutic intervention to a minimum during the crisis period. However, since it was obviously impossible to be the proverbial "fly on the wall," interviews inevitably provided a certain amount of nonspecific emotional support. In a few instances some degree of therapeutic contact was necessary in order to maintain a meaningful research relationship.

I. CONCEPTUAL FRAMEWORK

From time immemorial novelists and dramatists have stressed the significance of crisis periods in determining the fate of individuals and groups. The element that makes for dramatic excitement is the fact that crises have a peak or sudden turning point,

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² For a detailed exposition of this phase of the program, see M. B. Hamovitch *et al.*, "Establishment and Maintenance of a Mental Health Unit," *Mental Hygiene*, Vol. 43, No. 3 (July 1959), pp. 412-421.

³ *Ibid.*, p. 420.

⁴ John Bowlby, M.D., *Maternal Care and Mental Health* (Geneva: World Health Organization, 1952), p. 15.

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and as this peak approaches, tension rises and stimulates the mobilization of previously hidden strengths and capacities. Similarly, in our day-to-day clinical work we have long been impressed by the significance of periods of life crisis, which in the early stages of illness seem to determine its direction.⁵ However, our present knowledge of the extremely intricate relationship between family functioning and mental health bristles with methodological and conceptual difficulties. We are therefore still at a reconnaissance stage, where the most we can expect is to isolate useful questions and promising avenues of exploration rather than to aim for definitive answers.

When we evaluate mental health or ill health, we are implicitly or explicitly making a rating of an individual's equilibrium in adapting to his environment. Among the important criteria for this rating we include such factors as the individual's ability to (1) initiate and maintain satisfying emotional relationships with others, (2) work productively and fulfill inner resources, (3) perceive reality undistorted by fantasies, and (4) adapt to his environment if this is conducive to his welfare, or (5) change the environment, when not conducive to his welfare, in a way which impinges minimally upon the rights of others.

This equilibrium is kept stable by a complicated series of re-equilibrating or homeostatic mechanisms operating on both the intrapsychic and interpersonal levels.⁶ A crisis is a period of disequilibrium overpowering the individual's homeostatic mechanisms. During a crisis a person is faced by a problem which, on the one hand, is of basic importance to him because it is linked with his fundamental instinctual needs, and on the other, cannot be solved quickly by means of his normal range of problem-

solving mechanisms.⁷ In this connection it is important to stress that conflict and unhappiness are not synonymous with mental ill health;⁸ in fact, at the appropriate time and place the presence of conflict and unhappiness is a criterion of mental health. For example, the misery of mourning and the anxiety and tension of dealing with role transition or any demanding learning experience would be accepted by most of us as unpleasant emotions that inevitably accompany healthy ego adaptation. We must also beware of cultural and countertransference biases in evaluating patterns of family functioning as "healthy" or "unhealthy" without very clear reference to their effects on individual family members.

Hazardous life events likely to induce crisis reactions as defined by these two broad criteria—basic importance combined with difficulty of solution by familiar methods—include such commonly encountered stresses as pregnancy, birth, death, important role transitions (e.g., entering school, acquiring a new job, or getting married), incapacitating illness, and a wide variety of other happenings. Such problems demand solutions that are often novel in the light of the individual's previous life experience.⁹ During the period of disorganization normally associated with crisis, old conflicts, symbolically linked with the present problem, are revived. As we know from clinical experience, the way in which the "old" conflict was resolved influences the ego's method of adaptation to the current stress. By the same token, however, adaptive responses to the new stress often produce mentally healthy solutions to hitherto unresolved problems. Thus clinical experience abounds with examples of individuals and families

⁷ Caplan, "An Approach to the Study of Family Mental Health," *op. cit.*, p. 1027.

⁵ Gerald Caplan, M.D., "An Approach to the Study of Family Mental Health," *U.S. Public Health Reports*, Vol. 71, No. 10 (October 1956), p. 1027.

⁶ John P. Spiegel, M.D., "The Resolution of Role Conflict Within the Family," *Psychiatry*, Vol. 20, No. 1 (February 1957), p. 9.

⁸ For an interesting elaboration of this principle, see Marie Jahoda, *Current Concepts in Positive Mental Health* (New York: Basic Books, 1958), pp. 18-21.

⁹ Spiegel, "The Resolution of Role Conflict Within the Family," *op. cit.*, p. 15.

who "rise to the occasion" when confronted with crisis, thereby not only successfully mastering the exigencies of the current stressful situation, but also dealing more adequately with long-standing conflicts that had been suppressed or repressed.

In our framework for the study of the family in crisis, we find it useful to assemble and analyze data under the following basic classifications: (1) *family life-style*, which refers to the reasonably stable patterning of family organization, subdivided into the three interdependent elements of value system, communication network, and role system; (2) *intermediate problem-solving mechanisms*, which represent the family life-style in action in a situational crisis context that calls forth the family's efforts for coping with stress; and (3) *need-response pattern*, which describes the ways in which the family as a group perceives, respects, and satisfies the basic needs of its individual members.

FAMILY LIFE-STYLE

When the family faces a stressful event, its life-style places at its disposal a range of problem-solving possibilities from which the family members individually and collectively may choose according to their perception of the demands of the situation. As we have said, the essence of a crisis is that the situation cannot be easily handled by the family's commonly used problem-solving mechanisms, but forces the employment of novel patterns. These are necessarily within the range of the family's capacities, but may be patterns never called into operation in the past. Our analysis is complicated by the fact that the new solution, after a period of consolidation, may become a stable part of everyday functioning, thereby altering the family's future life-style.¹⁰

¹⁰ Hence the familiar observation that some families emerge from crises as stronger and more effective units, while others become weaker and still others become dismembered. See Earl Koos, *Families in Trouble* (New York: Kings Crown Press, 1946) and Reuben Hill, *Families Under Stress* (New

For our purposes, *values* refer to the system of ideas, attitudes, and beliefs which consciously and unconsciously bind together the members of a family in a common culture. This configuration automatically defines the meaning of certain critical situations and at the same time suggests ways of reacting to them. It provides definitions of the time dimension, contains concepts concerning the responsibility and worth of individual members of the family, points to certain commonly held life goals, imposes a framework within which the pursuit of—and risks connected with—the pleasure impulse take place, and involves a system of sanctions.

Our second major grouping in characterizing the life-style of a family is the patterning of *roles*. This patterning provides for a definition of what is to be done in a family (obviously influenced by the system of values), who is to do it, and who is to decide on allocation of tasks (leadership). Role-patterning make provision for carrying out family tasks on the basis of age, sex, and personality traits; it also provides sanctions for dealing with the neglect or poor performance of agreed-upon tasks, thus including the authority functions of the family.

The third dimension, *communication*, is a network for carrying messages and transmitting information, feelings, ideas, among the various family members of the nuclear family (internal communication) as well as between the family and the outside community (external communication). It includes definitions as to which messages are perceived as worth transmitting (again very much influenced by the value system) and provision of channels for transmission (word symbols, body behavior, gestures).

INTERMEDIATE PROBLEM-SOLVING MECHANISMS

When we refer to the intermediate problem-solving mechanisms triggered by the actual

York: Harper & Brothers, 1949), which has differential examples of stress profiles.

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impact of crisis, the word "intermediate" emphasizes the temporary, dynamic nature of processes in flux as compared with the more stable equilibrium of the life-style. Although certain family life-styles may be clearly seen as conducive to mental ill health, in that the group may actively overburden or inadequately satisfy the emotional needs of some of its members, in many cases what happens is that the life-style merely affords greater or lesser opportunities for such a state to develop. Whether it develops or not will be determined by the choices made during crisis periods. The current factors influencing maladaptive choices are, therefore, of crucial concern.

During the period when new solutions are being worked out, certain patterns can be recognized in which tension is reduced for the family as a group, but at the emotional expense of one or more individual members. This can happen in two main ways: *passively*, by *emotional neglect* through concentrating family energies in such a way that the needs of an individual are not attended to, though the details of his own role may not be important in reducing tension; and *actively*, by the *emotional exploitation* of a family member through investing him with a role which does violence to his needs as an individual.

In such cases we have observed that the emotional problem facing the family was not handled in terms of group action—whether because of poor leadership, disorders of internal communication, or other organizational inefficiencies. Thus the group could not augment the sum of the capacities of its individual members, or, still worse, even reduced its combined strengths by dissipation of effort. The exploitation mechanism, serving an important purpose in each family member's psychic economy, reduced group tension by allowing displacement of individual anxieties or ventilation of guilt in relation to an object acceptable to the value system of the family. We are beginning to tease out the factors which cause one or more family members to

be singled out by the rest of the group for exploitation in this manner. The Adams case, presented on page 8, is a vivid example of the use of emotional exploitation as an intermediate problem-solving mechanism.

To sum up, the intermediate mechanisms refer to the family's problem-solving efforts through various transactional, interactional, and intrapersonal methods for adapting to and dealing with the emotional difficulties associated with stress situations—in this case Mrs. A's tuberculosis and absence from the home. At some point in time, the use of these mechanisms produces certain re-equilibrating forces, which in turn may bring about (to use Spiegel's term) a "novel solution" to the problem. It is at this point on the time continuum that we say that one significant phase of the crisis is ended, and introduce our third area of inquiry, namely, the mental health of the individual member of the family as measured by the need-response pattern.

NEED-RESPONSE PATTERN

The *need-response pattern* provides a dynamic assessment of the mental health of an individual family member within the context of family interaction processes, thus furnishing a conceptual link between family functioning and the health of the individual. Certain types of basic needs may be considered relevant to mental health—such as (1) love for one's own sake, (2) a balance between support and independence with respect to tasks, (3) a balance between freedom and control with respect to instinctual expression, and (4) the availability of suitable role models. In analyzing the response to these categories of need expression, we are impressed by the importance of three separate and interlocking phases, namely, the *perception* of the needs of the individual by other family members and by the culture of the family, the *respect* accorded to these needs as being worthy of attention, and the *satisfaction* of such needs to the extent

possible in the light of family resources.

We are aware that evaluation of this triad of perception, respect, and satisfaction is very much influenced by sociocultural factors, since it is based upon our own views of the individual as a separate person in his own right, worthy of a measure of recognition and respect as well as an equitable share in the family's resources. Clearly, these criteria have to be judged differently in a different culture; modifications are also necessary from one socioeconomic class to another.

Assessment of need-response. The need-response pattern, which may be altered during a period of crisis, is an instrument for assessing the family's solution of the problem in terms of the mental health of its members. In elaborating its use we have explored a number of different methods of assessment in order to use it as a definable consequent factor in evaluating the mental health outcome of the family's intermediate problem-solving efforts.¹¹ After a good deal of experimentation, we decided upon a short-cut approach based on over-all clinical impressions. After each interview, the interviewer recorded his clinical judgment of the need-response pattern of each family member, based on inferences from verbal content and behavior of interpersonal significance. Frequent checks on these ratings were made on interview records and summaries by other staff members. These procedures enabled us to make satisfactory judgments about significant changes in need-response patterns.

During the crisis period there are often

¹¹ For example, we tried various types of systematic time-sample observations. Records were bracketed into interaction units, coded into need categories, and rated by independent judges. Using an adaptation of the Bales method (see *Interaction Process Analysis* [Cambridge, Mass.: Addison-Wesley Press, 1950]) reliability reached 0.80 to 0.90 after a short training period. However, this and similar methods proved uneconomical and unwieldy, and we still doubted whether we could place any more confidence in the validity of these ratings than those derived from our usual processes of clinical inference.

temporary shifts in the need-response pattern. We do not believe that temporary periods of low need-response are necessarily harmful to mental health. However, persistent need frustration is likely to endanger the future mental health of a given family member, and even "temporary" low need-response is likely to have an important effect on an individual's future mental health if it takes place because the individual is peculiarly vulnerable at a critical phase of development. One further caveat should be mentioned. Need-response material must always be evaluated very critically because of the possibility that signs of frustration are being covered up by adaptive reactions with the passage of time, so that at the stage where they would be most significant to judgments on the danger to future mental health, they may be absent. We must also realize that signs of emotional upset may be coincidental and due to causes other than need-frustration within the family under study.

For reasons of simplicity, the need-response pattern will be discussed for only one member of our illustrative family.

II. CASE ANALYSIS

Our case example in demonstrating this conceptual framework involves the Adams family, who were studied intensively for over a year. Our summary, extracted from a wealth of data, unavoidably excludes diagnostically rich life history material, neighborhood and extended kinship group affiliations, projective test data, and a great deal of medical and psychiatric information. Because of space limitations our analysis is focused on the interpersonal and transactional levels, although this is in no way intended to minimize the importance of individual psychological determinants.

Mr. A, a white 39-year-old factory worker, has a wife, age 37, suffering from tuberculosis, and three children: Alice, age 14; Susan, age 11; and Jackie, age 8.

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They were a fairly happy, stable family until Mrs. A's illness. A year prior to our introduction to the family by the public health nurse, Mrs. A had been admitted to a sanatorium with a diagnosis of pulmonary tuberculosis, but had discharged herself against medical advice after a few months' treatment. During the following months she remained at home and resisted the nurse's attempts to induce her to attend the health center for X-rays or treatment. Her physical condition proceeded—at first gradually and later rapidly—to deteriorate, the home became disorganized, and Mr. A and the children became quite miserable. Finally the nurse made direct contact with Mr. A and stimulated him to take effective action. He brought his wife to the clinic for a diagnostic work-up, despite her protests, and saw to it that she returned to the sanatorium, recommended by the physician as an urgent measure. She was admitted in July, in a state of physical and mental exhaustion. Two weeks later she developed epileptiform seizures, and a tuberculoma of the brain was suspected. In late September she developed tubercular meningitis and nearly died. She was given a new type of drug therapy and by mid-October began to show an almost miraculous recovery. Her subsequent improvement has been steady and uneventful.

We shall now discuss the life-style of the A family in the light of three interrelated factors—values, roles, and communication—which will be separated for purposes of convenient analysis.

LIFE-STYLE OF THE ADAMS FAMILY

Value System. The value system of the A family involves a mixture of prevailing American lower- and middle-class attitudes. The time orientation of the family emphasizes the present: "Let the future take care of itself—especially in time of trouble." This aspect of family structure favors the use of group denial mechanisms in dealing with future events likely to imply present pain, thus controlling the leakage of anxiety

in the family social system. In accordance with this orientation, the family's consumption pattern encourages impulsive purchases producing long-term indebtedness.

Humor is an important part of the family's culture. Teasing, joking, and good-natured ridicule are regularly used in a predictable manner for masking certain kinds of direct emotional expression which the family would find threatening and therefore shuns. Feelings calling forth these defensive maneuvers for which free emotional outlets are unavailable include: (1) anxiety, (2) dependence, and (3) deeper levels of aggression. Attempts at emotional expression in these threatening areas are likely to elicit from the family as a whole responses such as, "You're a character," "cry-baby" (for crying or admitting fear), "jerk" (for directly asking for emotional support not connected with a specific task—e.g., feeling lonely, missing mother, being unsure of one's identity). Jackie, the 8-year-old boy, whose behavior became quite threatening to the family during the crisis period, was often the target of much of this name-calling. With respect to the expression of dependency needs, positive value is attached to *not* asking for help with basic life goals outside the day-to-day routine of the family—such as help from the outside community involving advice, financial assistance, comfort and consolation.

The family's general life-style places a premium on the worth and value of children. Despite the emphasis on gratification of their own pleasure needs, both Mr. and Mrs. A have indicated their willingness to make sacrifices. The children, especially the girls, know they are loved and appreciated as persons in their own right and do not appear to have any major doubts about their importance in the family scheme. During previous periods of trouble the affectional ties between parents and children had been strengthened, thus underscoring the family's importance as a nest to protect its members against an often regarded harsh, unyielding outside world.

Fair play is an important part of the family code. Although the children are free to express superficial resentments and criticisms, the parents place high value on "not squealing." Most everyday sins of omission and commission are easily forgiven and forgotten. However, feelings about underlying instinctual needs—e.g., fears of desertion—are expressed in symbolic terms only, thus producing defensive formations which encapsulate underlying emotional problems, simultaneously holding the family in stable equilibrium.

Role Pattern. This system of values permeates the family definition of roles. In general, in the pre-crisis picture, the pattern of defining tasks, assigning them, and carrying them out had been rather loose and fluid but still functioned as part of a stable and workable system. A high degree of complementarity is manifested in the willingness to work together on the spur of the moment when a member of the family needs help with a specific task. Despite the over-all flexibility of the role pattern we can delineate broadly the typical role performance of the members of the family. For reasons of space, however, we shall concentrate on Mr. A's role position.

As the source of authority in the family, Mr. A is expected to take over in matters of discipline, which usually involves tongue-lashings and impulsive physical punishment. He is also clearly cast in the role of breadwinner, since Mrs. A has not worked since their marriage. There is no doubt in the minds of the family members that when they violate the fair play code they will be lectured or punished by their father. It is equally clear that after the punishment the matter will be forgotten. During periods of trouble it is taken for granted that Mr. A will assume responsibility for meeting the expressive needs of the children. This role flexibility—an important structural feature for survival in crisis—provides an automatic temporary method for filling the vacuum created by the mother's absence. It permits the family to retain its equilibrium and keep

tensions reasonably under control. Because of Mr. A's willingness to take up the slack, he has earned, both from his wife and children, considerable respect for his role as father and for his own needs when he, too, is temporarily thrown off balance.

The most important expectation in the role performance of the children is that they supply gratification to the parents. This is linked with the parents' personal dependency needs. The parents gain support from their relationships with the children in erasing some of the hurt, loneliness, and bitterness that are residual feelings from their own childhood experiences. Role-patterning, then, is highly influenced by psychodynamic factors. For example, both Mr. and Mrs. A have "guilty feelings" about expecting too much of the children—"They are only kids, what can you expect?" This aspect of role determination makes it difficult for Mr. A, during the crisis, to distribute appropriately and effectively the physical and emotional burdens resulting from the mother's absence from the home, thus demonstrating how one aspect of family life-style obviously influences intermediate problem-solving behavior during the crisis period.

A final aspect of role distribution is especially important in the light of what later happens to Jackie. Since the family's expectation is that a small boy cannot do much to help, he is not given any regular chores. Even during the precrisis period, Jackie was stereotyped by his mother as a "character" or "bandit"; these epithets were used to mask her feeling that the child was not getting enough attention or love. Because of this feeling, it was considered unfair to expect much of him. He was therefore deprived of a good deal of training in instinctual control and was given too much freedom to roam recklessly about the neighborhood.

Communication Network. The internal communication network of the family provides open channels for free interchange of all pleasant and gratifying news. All mem-

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bers of the family are normally talkative, particularly about happy tidings: for example, gifts, vacations, celebrations, good grades in school, special delicacies, information about mother's progress, jokes, and humorous neighborhood episodes. On the other hand, the communication network is much more restrictive in relation to unpleasant or anxiety-laden situations. The communication between Mr. and Mrs. A, for example, at the time of her initial discharge against advice is a clear example of the kind of nonverbal contact associated with unpleasant occurrences. At that time Mr. and Mrs. A had been longing for each other but had concealed their feelings of loneliness through an unspoken agreement to displace painful emotions on external events.

The same attitude about communication of painful experiences pervades the family's perception of other separation phenomena. For example, feelings about a couch used by Mrs. A during periods of illness were expressed symbolically rather than through direct statements. During the initial period of Mrs. A's second hospitalization no member of the family would sit on her "spot" on the couch, because to do so would acknowledge the mother's separation from the home, which in turn would trigger off feelings of anxiety. When the couch was finally moved, we observed a new kind of communication in motion, thus indicating a beginning state of readiness to be confronted with the reality of the mother's separation and its meaning for the family.

According to the family's democratic ethic, any member is free to originate a message or transmit information—subject to certain ground rules. The message to be conveyed must obviously be harmonious with the family's value and role patterns. This is, of course, true of any social system which is a going concern, the parts of which must be well integrated. We see dramatic examples during the crisis period when Jackie repeatedly shouts, "I want my mother! I miss my mother!" When he

openly expresses feelings tabooed by the family system, communication barriers are erected, immediately obstructing further discussion. On several occasions Jackie was attacked by other members of the family who told him quite forcefully "Shut up!" Consequently, a good deal of aggressive affect is discharged somatically, that is, through body gestures, transitory functional symptoms, and guttural noises.

THE IMPACT OF CRISIS

Using the life-style of the family as a backdrop against which the crisis drama takes place, it is now appropriate to consider our definition of the meaning and signs of crisis as applied to the A family. We shall mention briefly five related aspects of the perceptual meaning of crisis to the family.

1. *The stressful event poses a problem which is by definition insoluble in the immediate future.* The stress of tuberculosis and hospitalization is obviously beyond the control of the family as a group. The family has no knowledge of the duration and probable outcome of Mrs. A's illness.

2. *The problem overtakes the psychological resources of the family, since it is beyond their traditional problem-solving methods.* Despite their previous experiences with the same stress, at the crisis peak they verbalize feelings of helplessness because they cannot do anything about the mother's illness. They can only wait, hope, pray for a change—and trust the doctors! The problem is so massive that it overtakes traditional problem-solving mechanisms such as avoidance, denial, suppression, and masking of feelings. Because of its very enormity it cannot be pushed out of awareness.

3. *The situation is perceived as a threat or danger to the life goals of the family members.* Mrs. A obviously perceives herself in danger of dying when she urges her husband to promise to look out for the children. Mr. A is threatened by the realization that his much-cherished goal of family integrity is endangered when, near panic,

he blurts out, "Everything is going down the drain!"

4. *The crisis period is characterized by tension which mounts to a peak, then falls.* Tension reaches a peak in October, when a guarded prognosis is offered concerning Mrs. A's condition. Falling as the family begins to cope with the problem, it rises again in response to attendant stresses (such as Jackie's runaway episode in November), but does not again reach such a high level during the period under study.

5. Perhaps of the greatest importance, *the crisis situation awakens unresolved key problems from both near and distant past.* Mr. A's response to stress indicates, for example, a frightening reawakening of feelings of object loss associated with the death of his mother. Mrs. A's illness also evokes hitherto suppressed guilt feelings: "I messed up my life—didn't plan things properly." At the peak of stress, referring to ancient problems connected with earlier experiences, he groans in a tormented way, "I worked all my life and what have I got? Nothing!" Grinding hostility toward Mrs. A, previously held in check, finally emerges in full force: "I could shove my fist right down her throat!"

For the family as a whole, too, Mrs. A's illness and absence reactivate group problems of unfulfilled dependency needs and unexpressed aggression.

INTERMEDIATE PROBLEM-SOLVING MECHANISMS USED BY THE A FAMILY

Having established that the stress of tuberculosis is in fact a crisis-producing event, we now come to a brief discussion of the family life-style in action during the actual crisis period. The following is a highly compressed summary of how Mr. A and his children reacted to the impact of crisis, with particular reference to Jackie. The family's reactions are divided into three stages, overlapping along a time continuum. The first stage begins in July and continues until early September when Mrs. A's condi-

tion worsened. The second stage continues through early November and covers the period when Mrs. A nearly died and then began to recover; and the third stage coincides with her subsequent progressive improvement.

First Stage. July to early September. The initial response of Mr. A and his daughters to the hospitalization of Mrs. A is to defend themselves against the emotional implications of the problem. They deny feelings of anxiety for her welfare or pain at her absence, and in fact pretend to be relieved of the burden of caring for her. Their expressed attitude is a rather affected one of "good riddance to bad rubbish." They do not speak much to one another about her, and for the first two weeks Mr. A does not even visit her in the sanatorium. Mrs. A is, then, superficially extruded from the family group.

The housework is managed rather ineffectively by Mr. A and the girls. The home is even more untidy than it had been during the last few months when the mother had been seriously ill and had refused to visit the public health clinic.

On the day of the mother's admission to the sanatorium Jackie is sent for a few weeks to Mrs. A's parents, where he is not visited by other members of the family. Later he is brought home. He is quite miserable, cries profusely, freely proclaims his longing for his mother and his fears that the "doctors will kill her." The rest of the family, reacting with complete lack of sympathy to these outbursts, begin to show extreme hostility. They shout at him and beat him at the least provocation. They let him wander around the neighborhood without supervision and treat him as an outcast and a pest. At the beginning of this period Mr. A and his younger daughter, Susan, show some consideration for Jackie, but by the middle of it nobody has a kind word for him. In Mr. A's words, "The girls help me a bit in the house but Jackie's only job is to worry me."

Jackie in turn responds to being made the scapegoat with increasing misery and

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rebellion. He runs away from home on two occasions, overeats in a disgustingly gluttonous way calculated to provoke more hostility from the family, and begins to steal pennies from Susan's bank, no doubt to compensate for inner feelings of emptiness, but at the same time engendering more hostility from the group.

In this stage we see the family defending itself against its emotional problem by various denial mechanisms and relieving its unexpressed tension through focusing hostility and anxiety on Jackie, whose age and sex prevent him from taking over any of the absent mother's roles and whose uninhibited expression of feelings threatens the defenses of the other family members. Jackie's needs are being intensively frustrated, and he reacts in a characteristic rebellious way which aggravates the situation in a vicious spiral.

Second Stage. Early September to early November. During this stage the members of the family, individually and as a group, show signs of confronting their feelings about the mother's illness. They begin to talk to each other about the danger to her life and about how much they miss her in the home. They begin to show overt signs of anxiety, to weep, to suffer from sleeplessness and poor concentration. And they begin to support and comfort each other. These reactions reach a peak at the end of September, when it seems that Mrs. A is at death's door. At the crisis peak Mr. A, suddenly challenged to mobilize his latent strengths, becomes more effective as a leader in directing the activities of the household. He allots housekeeping tasks to the two girls; they carry out his instructions willingly, and the home becomes much tidier.

Simultaneously, Mr. A and the girls diminish their harassing behavior toward Jackie. They scold and beat him less and occasionally comfort him when he cries for his mother. He runs away from home during this period, and though he is soundly whipped upon his return, his father and

sisters verbalize a good deal of anxiety for his welfare while he is lost.

It appears that the increasing danger to Mrs. A's life during this period overpowers the family's defensive denial of their complex of emotional problems. Their tension is then released through abreaction of anxiety and mutual support and reassurance. They no longer need to relieve tension by resorting to a scapegoat mechanism, and Jackie's direct expression of feeling no longer threatens them. Also, the strengths of the family are mobilized by the increasing threat of Mrs. A's deteriorating condition.

Third Stage. After the end of October. Toward the end of October Mrs. A begins to improve, so that her life no longer appears in danger. At the same time a relative visits the home for a few weeks, acting as a mother substitute. Tension is relaxed in the family's day-to-day functioning, and the intensity of its emotional burdens is reduced. Their previous effectual handling of their problems is gradually consolidated, though not without some strain. They continue to express feelings of anxiety and longing quite openly and to gain much comfort from mutual support. During this stage, Jackie is received back into the family fold as a member in good standing. Formerly regarded as a pest with no useful job to perform, he is now assigned a role consistent with his age and capacities—is allowed to help with minor household chores. He changes dramatically from the role of a wretched rebel to that of a responsive small boy, and although he continues to steal pennies occasionally, Mr. A speaks compassionately about this behavior, saying, "When he gets home from school and feels the need for his mother, I suppose the next best thing is to go and take something from his sister." Thus we see, during the later stages of this problem-solving period, that the A family is able to forge a novel solution to its problems by learning, under the impact of stress, to cope directly with reality

difficulties through open acknowledgment of sources of tension and anxiety.

NEED-RESPONSE PATTERN OF JACKIE

In reviewing briefly the resultant need-response pattern with respect to Jackie, we notice increased perception, respect, and satisfaction of his basic mental health needs. Specifically, our analysis reveals a heightened response to his need for affection, dependency gratification, and support in regard to physical tasks. As a result, he presents a considerably brighter appearance, discontinues runaway episodes and stealing, improves in school performance, and in general is a much happier youngster. These improvements in Jackie's level of need satisfaction are also reflected in certain changes in the family's role and communication patterns. Emancipated from the unhappy role of "pest" or "worrier," Jackie now begins to carry out the simple tasks assigned to him. When, in his eagerness to help, he attempts tasks beyond his capacity, his father firmly yet gently prevents him from doing them. Another interesting sign of the resultant changes in Jackie's mental health picture is apparent during a school vacation when he is again sent for a visit to his grandmother's house. Whereas during previous separations the family avoided seeing him, this time Mr. A not only telephones but also visits, and reports that Jackie perceives the visit to grandmother's as a "vacation" rather than another depriving experience in his life.

A number of follow-up interviews indicate that Jackie's emotional health continued to improve after the harrowing experience of the crisis period. His morale received a tremendous boost when his mother, because of her improved condition, was given permission for a brief visit to the home. Jackie minced no words about his desire to "sit right next to Mother at the table," nor did the family in any way disapprove of this direct expression of feelings.

A few significant changes in various phases

of the family's transactional behavior, having important implications for the future mental health of the family members, are also worth mentioning. The family's value system is characterized by greater tolerance of painful events, and concomitantly there is a shift from present toward future time orientation (advanced financial planning for purchase of furniture, increased willingness to ask for help from social service and other care-taking agencies). In allocating roles, Mr. A is able to maintain a position of reasonably effective leadership. The children take initiative in doing things "to surprise Dad" when he comes home from work. As a result of the crisis experience, channels of communication are less constricted for the discussion of anxiety-laden topics. For example, Mrs. A's vacillation in returning to the hospital following a home visit was discussed very directly in the family, resulting in a healthy type of quarrel and open expression of anger toward Mrs. A, eventuating in resolution of the problem by Mrs. A's request that Alice, the older daughter, call her husband at work and inform him of her decision to return to the hospital.

Because of limitations of space, this survey has focused upon the resultant need-response pattern of only one member of the family following a sequence of crisis events. A more extensive analysis would appropriately be concerned with a systematic review of the functioning of the family in relation to resultant factors influencing the future mental health of each member.

CONCLUSION

Using the concepts of family life-style, intermediate problem-solving mechanisms, and need-response pattern, we have presented an approach to the observation and study of the family in crisis. We have briefly demonstrated this conceptual framework by tracing the need-response pattern of one member of a family through a series of crisis events to which the family reacted

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with a range of mechanisms, described in the general context of its value, role, and communication patterns. It is hoped that in subsequent investigations this approach will be useful for developing additional formulations concerning a typology of family structures, crisis-problem classification, and the dynamics of crisis behavior in relation to family mental health.

Finally, our study of families in crisis—including a range of selected cases in which methods of preventive intervention were deliberately used—suggests a number of implications for the development of a rationale and technique for preventive programs in public health and other settings.¹²

We are impressed with the need for precise articulation of focused casework techniques of anticipatory guidance, support, and clarification. Of particular importance is the need for reliable predictive guides for precision in timing efforts at intervention while the family is in the throes of crisis, so that a minimal therapeutic force will produce maximal benefit.

¹² Caplan, *Emotional Disorders of Early Childhood*, op. cit., pp. 153-163. For a thoughtful appraisal of some technical problems, see Bertram M. Beck's statement on "Prevention and Treatment," based on the work of the Subcommittee on Trends, Issues, and Priorities of the NASW Commission on Social Work Practice (New York: National Association of Social Workers, May 1959). (Mimeographed).

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BY AGNES RITCHIE

Multiple Impact Therapy: An Experiment

THE YOUTH DEVELOPMENT PROJECT, a unit of the Neuropsychiatric Department of the University of Texas Medical Branch at Galveston, came into existence about 1952 to provide a specialized service of therapy and counseling for teen-agers and their families; to offer to medical students, nursing students, residents, and members of related professions an opportunity to study the adolescent and his problems and to learn some techniques of treating them; and—by no means least—to develop and test new ideas, new theories, new techniques of helping. In short, the functions of the Youth Development Project include service, teaching, and research.

Since the Medical Branch serves the entire state of Texas, patients may be referred from any of the 254 counties in the state. The staff and medical consultants of the Youth Development Project faced repeatedly the frustration of having to recommend long-time therapy and counseling for adolescent patients and their families who

lived in communities where such treatment was not available within a fifty-mile radius—if they could afford it, which many could not. The wish and need to offer help and hope to some of these troubled adolescents and families, many of whom were desperate, was at least as strong a factor as any other in the development of the *multiple impact therapy*.

Multiple impact therapy (referred to familiarly within our agency as "MIT") is a brief, usually two-day, intensive study and treatment of a family in crisis by a guidance clinic team.¹ In our project the team includes a psychiatrist, clinical psychologist who is also research director, a psychiatric social worker, and a resident clinical psychologist. The multiple impact therapy team has the benefit of regular consultation and supervision of senior staff members of the Department of Neurology and Psychiatry, as well as opportunity for consultation with Medical Branch staff and personnel. The team devotes full time, six or seven hours a day for two (sometimes two and a half) days, to one family. Families come to the clinic frequently from a considerable distance, anywhere from 50 to 450 miles, sometimes viewing the trip to Galveston as their last hope.

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¹ Brief descriptions of the psychotherapeutic procedures from the standpoint of their personal experiences with them have been given by Dr. Goolishian before the American Orthopsychiatric Association in San Francisco, March 1959; by Dr. MacGregor before the Southwestern Psychological Association in Topeka, May 1959; and by Dr. Schuster before the American Psychiatric Association in Philadelphia, April 1959. This writer has also presented a description of the procedures at a meeting of the San Jacinto Chapter of the National Association of Social Workers in February 1959.

Multiple Impact Therapy

The multiple impact therapy plan is based on two assumptions. First, that individuals and families facing a crisis are stimulated to mobilize strength and resources to meet it, and that they are more receptive to interpretations, more likely to be flexible in attitude, than at other times. The second assumption is that in any type of psychotherapy there is likely to be faster and more dramatic change in the early stages of treatment, and that under long-range treatment later change and improvement is more gradual—is a deepening and strengthening of the initial movement, during the first few hours or weeks, toward improved health or adjustment.

The procedures are quite flexible, but consist essentially of an initial family-team conference, followed by a series of individual interviews, joint interviews (two patients with one or more therapists, or two therapists with one or more patients), and overlapping interviews—all these procedures being interrupted by formal and informal team conferences. The family, also, is advised to talk together, to share thoughts, ideas, insights, and feelings, both about themselves and about the clinic experience and the clinic team. Psychological tests are given the adolescent during the first afternoon, and results are shared, in a general way, with the parents and the adolescent, usually early on the second day. The two-day contact terminates with a final family-team conference, sometimes with the adolescent present but sometimes not, and it is in this last conference that "the back-home problem" is discussed in terms of specific recommendations and insights gained during the preceding day and a half are applied to behavior and situations that can be anticipated. This whole project at present is primarily research and demonstration; the family is told of the plan for a follow-up conference six months later, and they understand that this is primarily for the benefit of the research team, to evaluate results of our work with the family, although they are also assured that additional con-

sultation or service from us is available to them, either at the end of six months or earlier if a new crisis arises.

An important feature of multiple impact therapy procedures is the "overlapping interview," in which a team member who has been talking privately with a family member terminates his interview and joins another conference, either alone or accompanied by the person he has been seeing. One or the other of the team gives a brief summary of the conference up to this point. This summary not only informs the newcomer, but gives the patient an opportunity for critique of the therapist on the accuracy and interpretation of what has gone on between them and of the work with the family. Differences of opinion or of interpretation between two parents, or between parent and child, are sometimes aired and resolved in these overlapping interviews.

Differences of opinion or interpretation between team members are also brought out and discussed fully in the family's presence. In some families this freedom in the team to disagree—sometimes with heat, but with no decrease in mutual respect or ability to work together effectively and to remain friendly—has tremendous impact on the family; they are exposed to a demonstration rather than an exhortation to express feelings as well as thoughts. Sometimes they are invited to participate in the discussion, which conveys our confidence that they are not so fragile that they cannot bear to disagree with us or with each other. Frequently differences are not resolved, and we comment, explicitly, that there is frequently room for different interpretations and methods of handling problems, and we express confidence in the individual's or family's ability to find their own answers and solutions. In a few instances, where communication within the family is so poor that no interchange occurs, the team members may present deliberately different versions or interpretations of some material that has been presented, each arguing for the validity of his point of view, with the

patients being invited to participate, even to "take sides."

PROCEDURES

The procedures for our multiple impact therapy are generally as follows: the clinical team meets together before the family arrives, and reviews briefly the information already available about the nominal patient, the family, and the situation. This information may have been furnished by the referring person or agency (such as the family doctor, the John Sealy Hospital or outpatient clinic, a school, or a social agency); or the applicants may have been seen previously by our clinic staff for brief screening interviews. In the initial team conference there is usually some speculation about family dynamics and the genesis of the presenting problem, and some tentative plans are made for distribution of labor among the team during the first day, or at least the first morning of the contact.

The family has been advised to arrive at the clinic at nine-thirty in the morning, and at about that time they are invited to meet with the team in a conference room. The initial family-team conference is usually planned to last about an hour, during which time a great deal may happen. There are first introductions all around, the family's attention is called to the tape-recording equipment; in suggesting seating arrangements both the distance and the position of each person in relation to microphones is considered, as well as separate chairs for family members (so that they will not sit together on the couch and run the risk of feeling that they are huddled together against an imposing array of "experts").

After a very few moments spent in amenities and in getting settled, the family is invited to explain the problem to us or—since they know we already know why they are there—to bring us up to date on the current situation. Almost invariably one family member will act as spokesman initially, and we encourage participation from

the others; all our questions and comments to encourage participation are worded in a way calculated to convey respect for the feelings and opinions of each member of the family, and to convey our recognition, sometimes verbalized, that the behavior of each, whatever it may have been, must have "made sense" at the time if viewed in the light of interpersonal relationships and attitudes, or in terms of the total situation.² For example, when parent or parents describe the patient in terms of his difference from another child who is, for example, more obedient or respectful, or more industrious, one of us will usually address a question or comment to the adolescent about sibling relationships: *e.g.*, "Your brother seems to know how to get you in bad with your folks. What do you do to get him in bad?" Or to the woman who cashed rubber checks on her husband's bank account, "It looks like you just had to see if your husband would stand by you!" Or perhaps we would say to her husband at that point, "Mrs. S seems to trust you enough to know that you would protect her!" Interpretation and even speculation by the team are begun very early, usually in the opening conference. For example, when the chief complaint is "school phobia," questions about the problem are couched in terms of the child's "fear to leave home," with verbalized speculation by team members about conscious or unconscious fears the child may have as to what might happen at home in his absence. The theory of the Oedipal conflict and its application to the family problem and the crisis are presented usually in simple nontechnical words.

INDIVIDUAL INTERVIEWS

Not infrequently there is more communication between family members and more sharing of feelings both positive and negative in the initial conference than has oc-

² Robert MacGregor, "Multiple Impact Psychotherapy with Families." Paper read at Southwestern Psychological Association, Topeka, May 1959.

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curring in the family for many years, if ever. However, unaccustomed as most families are to this free communication, considerable tension is built up from things none feel free to say before the others. Usually after about an hour one team member will suggest that we separate into individual sessions, and each team member invites a family member to accompany him to a private office. Although pairing off at this point is extremely flexible, most commonly the psychiatrist will see the adolescent patient after the initial conference, the social worker (who in our team is a woman) interviews the mother, the psychologist interviews the father, and the second psychologist interviews any other participant; it may be another child in the family, or a close relative who lives in or near the home and is an important person in the child's environment, or a referring person (social worker, probation officer, school counselor) who for one reason or another has accompanied the family to the clinic. When only the adolescent and two parents are with us, the fourth team member may participate in one of the individual interviews—may conceivably "visit" from office to office, permitting more use of the overlapping summary technique described—or may withdraw for the balance of the first morning.

The individual interview with the adolescent gives the child an opportunity to receive undivided attention from the doctor, to "present his case" and his side of any argument, and to ventilate his feelings more freely than he could in his parents' presence; at the same time it gives the psychiatrist an opportunity to form a diagnostic impression of the patient. If it was not mentioned in the earlier group meeting, the patient is told about psychological tests that will be given him after lunch, and any anxiety or resistance about this can be handled immediately. Individual interviews with adolescents are shorter than with adults, and the staff member who has seen the boy usually calls by phone for permission to join an interview with one or the other parent.

These initial individual interviews with the parents are frequently used by them to ventilate grievances and present defenses and rationalizations, each for his or her behavior and attitude toward spouse, patient, and community.

GATHERING INFORMATION

There is very little "history-taking" as such, but relevant family history, developmental history of the adolescent nominal patient, of the other children, and of parents themselves is usually brought out in these sessions as this information, in the parent's mind, is pertinent to the problem or as explanation or defense of his own attitude, behavior, and so on. The therapist soon has an opportunity, either in an overlapping session immediately following the interview or in a later joint session, to review relevant history briefly, integrating it into history or rationalizations presented by other members of the family and/or condensing or rephrasing information in an interpretive way.

The family is advised at the end of the morning to share as freely as they can with each other any ideas, insights, or reactions they have had during the morning, and are told that the team, also, will confer during lunch, sharing information and ideas with each other, so that work can be continued together during the afternoon. This same recommendation is made to the family at the end of the day, and some of the most dramatic improvements in communication between family members, and especially between parents, occur away from the office.

During the afternoon of the first day the adolescent is usually given a battery of psychological tests. Parents are seen individually at first in what we call "cross-ventilation interviews," in that the team member who has seen the father in the morning now sees the mother, and vice versa. By this time each team member has some fairly clear-cut impression of the strengths and weaknesses of each parent; the one who has

seen the mother for an hour or more has some appreciation of what Father "has to put up with." Discrepancies and distortions not uncovered in overlapping sessions during the morning come to light as the team confers during and after lunch, and during subsequent sessions cloudy areas are clarified, not only by team but also by patients.

Probably the dominant leitmotif of the team's activity with the family is the emphasis on each member's role in the family: the delineation and spelling out of the appropriate role of father, of mother, of child. In most of the twenty-six families seen during the past twelve months, mothers have been—with a depressing uniformity—preoccupied with motherhood, and the fathers frequently preoccupied with job or with hobby, sometimes to the point of being psychologically excluded from the family; more than one father has seemed and has felt more like a roomer or boarder than a husband and father. Many mothers have defensively protested about their endless efforts to be a "good mother" and have offered (much too readily) to accept full responsibility, even guilt, for the children's difficulties. Both directly and indirectly we have encouraged parents to "rediscover each other," to seek and share adult interests, companionship, and recreation with each other and with their peers. We attempt to build up the father's confidence, and his wife's, in his ability to function as the head of the house. We point out to the mother and to her husband her feminine attractiveness (actual or potential) and express concern that she is denying herself adult feminine satisfactions in life, giving them up to live in a children's world. The unconscious emotional exploitation of children by parents who are no longer giving and receiving tenderness and emotional satisfaction from each other, and the obstacles this places in the maturation of the children, are frankly presented in simple nontechnical language as a common phenomenon occurring in many families, and

the applications made as this operates in the particular family.

The second day is an accelerated version of the previous day, usually starting with a brief team-family conference, followed by individual and joint sessions. The decisions as to "who sees whom" and in what combinations are based on evaluations as to relationships established between a family member and a team member or on the team's judgment as to the effectiveness of certain special attributes or attitudes of individual team members. Overlapping interviews are more freely used on the second day, and by this time the rewards of freer communication are sufficiently appreciated by the family members so that usually no objection is raised to sharing with each other newly discovered insights. This disintegration of the usual confidentiality, with the knowledge and approval of the confider, seems to be a criterion of the family's trust in the team and increased trust and confidence in each other.

The final conference, which occurs during the last hour or two of the second day, has been described earlier and is usually devoted to discussion of the "back-home problem," with much more active participation by both parents than in the opening session.

TENTATIVE EVALUATION

A wide range of presenting problems and types of crises have been treated by these methods during the past ten months. These have included chronic runaways, delinquent acting-out behavior, school failure and school phobia, homosexual behavior and other sexual deviations, and so on. In fact, the diagnostic categories have included the range from adjustment reactions through the schizophrenias. Six-month follow-up evaluations have been done on all twelve families seen during the pilot study and on seven families of the current series, with quite promising findings. Institutionalization of the adolescent, either in a correc-

Multiple Impact Therapy

tional school, a mental hospital, or some other residential facility, seemed imminent and inevitable in many cases, but has been avoided (or at least postponed) in all but two instances. This is a very gross measure of success, but repeat psychological tests and professional evaluations of change or improvement in various areas of individual and family adjustment indicate that the effectiveness of this type of treatment for the limited number of families seen so far is as great (statistically) as the longer type of conventional therapy. It should be mentioned that as many professional manhours of time are invested in each family we have seen as in six months or more of one-hour-a-week appointments in conventional, individual therapy. A three- or four-member team devoting six or seven hours a day for two days represents between thirty-six and fifty hours of interviewing and conferring, without counting preliminary correspondence and/or conferring, recording, and the like.

Among the twenty-six cases studied during the past year, two families in which the crisis centered around a preadolescent child were included successfully, and it seems evident that the multiple impact therapy procedures are equally applicable to this kind of family. In six of these twenty-six families the "crisis" situation was the return of the adolescent to the home and community following a period of institutional care in a training school or a psychiatric hospital. These youths had the benefit, of course, of the training and treatment services of the institutions, but prognosis for satisfactory adjustment in the home environment was considered poor in each case; by this is meant that the physicians and agencies who referred these cases to the Youth Development Project expressed the opinion that the adolescent patients would quickly regress to the earlier deviant and antisocial behavior which precipitated their removal from home and community. In the four of

these six families in which formal follow-up evaluations have been made, this has not happened. On the other hand, family structure has been strengthened, parents are more supportive, each of the other, and more accepting and more realistically firm with the children, and after a period of testing these new strengths and the new limits imposed by parents, the adolescent nominal patients have been able gradually to settle down into reasonably acceptable and appropriate behavior patterns.

Children's institutions and placement agencies have long recognized that planning for discharge is at least as important and in many ways more difficult than initial planning and preparation for placement. Ideally, discharge planning is a part of the work with child and family throughout placement, but frequently this is impractical or sporadic. If an adaptation of multiple impact therapy can be used as part of discharge planning, this will be a valuable tool for many types of institutions.

Much study remains to be done before the possibilities and the limitations of this approach can be clearly understood and described. Originally developed to meet a particular problem in a rather specialized clinic, multiple impact therapy procedures have already proved flexible and adaptable for use in several different settings, and in the treatment of a variety of individual and family problems. Several outpatient clinics have expressed an interest in planning for demonstration or use of multiple impact therapy in their own agencies, and indeed have experimented successfully with these techniques, or with a modification of the procedure adapted to their own agency needs and staff resources. Our experience to date has indicated that this type of procedure will prove a valuable addition to the therapeutic tools of guidance clinics, hospitals, residential treatment centers, and so forth, as well as a teaching device of merit in the training of mental health workers.

BY ROSE BERNSTEIN

Are We Still Stereotyping the Unmarried Mother?

THE THEORY OF out-of-wedlock pregnancy currently accepted among social workers and members of other helping disciplines is that it is symptomatic and purposeful, an attempt by the personality to ease an unresolved conflict. The extent to which we are committed to this point of view can be seen in some typical excerpts from the literature.

The caseworker should recognize that pregnancy for the unmarried woman is a symptom of underlying emotional difficulty. [She] is a person who solves her emotional problems through acting out, as exemplified by the pregnancy.¹

We recognize unmarried motherhood as a symptom of a more pervading personality difficulty.²

Her illegitimate pregnancy is the result of an attempt to solve certain emotional conflict. . . .³

[The unmarried mother] . . . has failed to attain a mature pattern of adaptation to the demands of her social reality.⁴

. . . everything points to the purposeful nature of the act. Although a girl would . . . not plan consciously . . . to bear an out-of-wedlock child, she does act in such a way that this becomes the almost inevitable result.⁵

The popular magazine articles have been echoing this point of view.

In many situations it is a useful approach. The results of treatment are often dramatic and gratifying when a girl is able to make use of help in understanding and dealing

with some of the underlying problems related to her out-of-wedlock pregnancy. However, in contacts with residents in a maternity home, and particularly in reviewing material for a study, one becomes concerned about the limited applicability of this theory in a number of cases. One has the impression that in some situations factors other than, or in addition to, underlying emotional pathology have been of greater significance; that emphasis on a single point of view has prevented us from seeing other essential aspects of the experience and, correspondingly, has resulted in a limited treatment offering. This has seemed a good time, therefore, to re-examine the theory and look at other hypotheses which might be applicable in our work with unmarried mothers.

SOCIAL MORES

By and large, unmarried motherhood in our society is looked on as the violation of a cultural norm. It should therefore be possible to isolate and identify the norm in question. But this is not easy. For one thing, it is not clear whether the offended norm is

¹ Margaret W. Millar, "Casework Services for the Unmarried Mother," *Casework Papers 1955* (New York: Family Service Association of America, 1955), p. 93.

² Louise K. Trout, "Services to Unmarried Mothers," *Child Welfare*, Vol. 35, No. 2 (February 1956), p. 21.

³ Jane K. Goldsmith, "The Unmarried Mother's Search for Standards," *Social Casework*, Vol. 38, No. 2 (February 1957), p. 69.

⁴ Irene M. Josselyn, M.D., "What We Know About the Unmarried Mother." Paper read at National Conference of Social Work, June 1953.

⁵ Leontine Young, *Out of Wedlock* (New York: McGraw-Hill Book Co., 1954), p. 22.

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the taboo against extramarital relations or against bearing a child out of wedlock. We point to the symptomatic nature of the pregnancy ("there are no accidental conceptions"), but in speaking of prevention we are unable to clarify what we are trying to prevent—unsanctioned sex experience or out-of-wedlock pregnancy.

Some communities are more or less resigned to wide-spread sexual experimentation (among teen-agers), yet indignantly aroused and condemning when such experimentations result in out-of-wedlock pregnancy.⁶

If one observes public reactions today, one can hardly escape the conclusion that it is not so much the sexual relationship to which we object as the fact of the baby.⁷

Actually we are not dealing with a single norm, but with a multiplicity of norms which will vary according to cultural and ethnic groups, social or educational sophistication, peer practices, and so forth. These norms will vary not only from one girl to another but also for the same girl, according to the group she is most strongly related to at a given period in her life. The girl whose group or family loyalties at the age of seventeen preclude sexual experience may be safer from out-of-wedlock pregnancy at that time than she is at the age of twenty-two, when her major satisfactions may reside in a group whose climate sanctions or invites such activity.

Our society has been undergoing a change in its sexual behavior. The relaxation of taboos which usually accompanies the upheavals of war has been accelerated in the last two generations by the development of a widely publicized psychology. Permissiveness, self-expression, sexual adjustment, and freedom from inhibition have become in some quarters the marks of the well-adjusted American. The idea of extramarital sex

experience is accepted among many college students; among some groups its practice is almost a social *sine qua non*.

However, the professed code of behavior has not kept pace with the changing practices, and the ideal of chastity and marriage continues to be cherished along with other cultural fictions.⁸ As long as the violation of the professed value is conducted with a decent regard for secrecy or is not otherwise detected, society is content to accept the implied and overt contradictions resulting from the gap between our professed and operational codes.

Most adults sooner or later arrive at some sort of equilibrium in this cultural tight-rope-walking act within which their satisfactions and their consciences manage a reasonably peaceful coexistence. For the young person searching for standards such a balance is not so easily achieved. When those from whom her standards are to be derived—the guardians of our social mores—are operating on more than one set of values, it is not surprising that she herself should question the validity of the professed code. The realism in the seemingly cynical "It's just that I was unlucky enough to get caught" cannot be lightly dismissed.

The uncertainty in our point of view as professional people may well be a reflection of the confusion in the society in which we participate and the role to which the community assigns us as social workers. As members of contemporary society we tolerate the original sexual activity. In deriving our social attitudes from the society that fosters the agencies we represent, we are expected to deplore the activity when confronted with its outcome. Identified with the unmarried pregnant girl who must hide from a censoring community, we reach out to comfort and counsel her. In addition we have our own private views to deal with. To say that a girl is in some respects an inevitable casualty of social change would al-

⁶ Lola A. Bowman, "The Unmarried Mother Who Is a Minor," *Child Welfare*, Vol. 37, No. 8 (October 1958), p. 13.

⁷ Leontine Young, *op. cit.*, p. 6.

⁸ For an extended discussion of this problem see Max Lerner, *America As a Civilization* (New York: Simon & Schuster, 1957), pp. 657-688.

most make it appear that we approved of her sexual activity. We are uncertain as to what stand we should take toward extra-marital sex experience, or whether we wish to take a stand at all. Yet a noticeable increase in the incidence of illegitimate births compels our attention. We are indeed on the multiple horns of a dilemma.

The extension of unmarried motherhood into our upper and educated classes in sizable numbers further confounds us by rendering our former stereotypes less tenable. Immigration, low mentality, and hypersexuality can no longer be comfortably applied when the phenomenon has invaded our own social class—when the unwed mother must be classified to include the nice girl next door, the college graduate, the physician's or pastor's daughter. In casting about for an appropriate explanation for her predicament we find it more comfortable to see the out-of-wedlock mother as a girl whose difficulty stems from underlying, pre-existing personality problems. We are forced into the position of interpreting the situation primarily in terms of individual pathology, failing to recognize the full extent to which the symptom may be culture-bound. We do, when pressed, acknowledge the possible influence of cultural factors, but in the main we do not tend to incorporate these elements significantly into our thinking.

There are no ready answers to this perplexing question, but as social workers we cannot adequately deal with the problem of the unmarried mother unless we see it within the framework of our conflicting mores. We must make room in our thinking for factors in the social scene—not only as they contribute to unwed motherhood, but also as they color the girl's reaction to her out-of-wedlock status in pregnancy.

It is understandable that we should incline toward a theory of underlying pathology as the cause of unmarried motherhood. Frequently, when we see the illegitimately pregnant girl, she presents a picture of severe disturbance. Guilt, panic, suspicion, and

denial are not uncommon reactions. More often than not she will give a history of deprivation in primary relationships. However, if we are to assess correctly the sources and appropriateness of these reactions, we must take into consideration the circumstances under which we are seeing them. Two compelling factors in these circumstances are the crisis itself and the specifics of pregnancy and maternity. They are important not only for their diagnostic meaning but also because of their implications for practice in our work with unmarried mothers.

CRISIS

We know that in a crisis situation current functioning may be disrupted, past vulnerabilities exposed, and hitherto manageable conflicts stirred up. Earlier feelings of guilt, deprivation, and the like may be reactivated. The unmarried pregnant woman, seen at a point of crisis, may exhibit a whole range of disturbed reactions. To be sure, each girl will experience her unwed motherhood in accordance with her basic personality make-up and will integrate it into her own patterns of reaction and behavior. However, crisis can produce distortions of one's customary patterns, and we cannot assume that her reactions in a crisis situation represent her characteristic mode of adaption to reality any more than we can say that an acute pneumonia is characteristic of a person's physiological endowment, even though he may have some pulmonary susceptibility. A girl may become an unmarried mother because she has had pre-existing problems, or she may be having problems because she is an unmarried mother. Her behavior may be a true reflection of underlying emotional pathology, or it may be an appropriate response in an anxiety-producing situation. She may be manifesting primarily a resurgence of the latent guilt and unresolved conflicts which are ingredients in all human adjustment and which have been stirred up under acute stress.

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Unmarried mothers as seen in a maternity home appear to experience these crises in stages, with periods of relative calm between, rather than in an unbroken line. Each girl seems to have her own pattern of stress alternating with well-being. For each the crisis-precipitating factor seems to be different at different times. It may be related to elements in the pregnancy. ("The emotional crises of pregnancy are produced mainly through stimulation by biological processes within the mother. . . .")⁹ or it may result from news of the baby's father, her own parents, or some other external source. Our knowledge and experience are rather limited in this area. Perhaps we should be directing some of our efforts toward learning to recognize the signs of these crises, in order to anticipate and prepare for them if possible—to know when intervention is indicated and when the potentials for self-healing inherent in crisis situations had best be left to do their own work; to try to understand so that we may learn to deal with the rhythms of crisis in the unmarried mother.

A recognition of the crisis factor in unmarried motherhood should give us pause in our routine use of psychological testing of the resident in a maternity home, and in the requirement for prescribed casework interviews. One may hope that it will prompt us to interpret with great caution the results of projective tests and questionnaires, devices which appear to be taking on increasing importance in the diagnosis of unmarried mothers. Personality traits registered at a time of crisis, though applicable to the time and circumstances under which the tests are administered, can be interpreted in only a limited way as ongoing characteristics of the unmarried mother, individually or as a group. (The provocative nature of some of the test questions might also be considered.) Otherwise we are likely to emerge with a personality picture that does not fit the observations of many of us who are see-

ing unmarried mothers in their day-to-day living.

Note some conclusions from a recent study:

... acting out anti-socially is a primary characteristic of the unwed mother. . . . There does not appear to be much difference between the unwed mother and other delinquent females.

The unmarried mother is bitterly hostile . . . more so than all patient groups. . . .

They are unfitted for psychotherapy because they deny problems and in their defensiveness appear aloof and independent, thus rejecting help and their basic dependency needs.¹⁰

PREGNANCY AND MOTHERHOOD

It is generally accepted that the experience of pregnancy can contain elements of crisis even for the married woman. "So-called 'normal pregnant women' might be highly abnormal, and even if they are not, they are anxious to a degree beyond that of the so-called 'normal non-pregnant female.'"¹¹ "Particularly during the first pregnancy women are apt to suffer terrifying dreams and phantasies of giving birth to a dead or misshapen child."¹² With the additional pressures to which the unmarried pregnant woman is subjected, we should not be surprised to see an intensification of the reactions which in her married counterpart we are prone to accept with tolerant indulgence. In themselves they are not necessarily signs of severe pathology. By the same token, the "normal deviations" of adoles-

⁹ Edmund Pollock, "An Investigation into Certain Personality Characteristics of Unmarried Mothers." Unpublished doctoral dissertation, New York University, 1957, pp. 103, 110, 141.

¹¹ J. C. Hirst and F. Strousse, "The Origin of Emotional Factors in Normal Pregnant Women," *American Journal of the Medical Sciences*, Vol. 196, No. 1 (July 1938), p. 98.

¹² Florence Clothier, M.D., "Psychological Implications of Unmarried Parenthood," *American Journal of Orthopsychiatry*, Vol. 13, No. 3 (July 1943), p. 541.

⁸ Gerald Caplan, M.D., from a lecture delivered in Cleveland, June 1953, to the first annual convention of the National League of Nursing.

cence should figure prominently in our assessment of the meaning of out-of-wedlock pregnancy in the teen-ager.

Pregnancy and parturition constitute a continuing experience in physiological and emotional change. Each period seems to have its biological characteristics and typical emotional concomitants. There is still much uncharted territory in our knowledge of this psychobiological phenomenon, but obstetricians, psychiatrists, and others working with married pregnant women are becoming increasingly interested in the importance of these factors. As members of a helping discipline we have an obligation to incorporate into our work with the unmarried mother whatever relevant information is available. We may not be able to apply it very specifically as yet, but recognition of the significance of such factors can influence the ways in which we respond to a girl's reactions, the areas in which we offer help, and the manner in which we offer it.

It can affect our decision whether to reassure or to explore for deeper meaning at a given point. It may influence our interpretation of a girl's dependent leaning toward her mother or a mother-person. It will have a bearing on our reaction to her apprehensiveness about her growing attachment to a baby which she must relinquish—the ease with which we can help her to accept herself as a prospective mother and experience pregnancy and motherhood in as constructive a way as possible. It will have much to do with the strength we can lend her in the face of a separation from her baby, so that she can liberate and experience her feelings of motherliness toward her child. The “some day if I marry and have a baby of my own . . .,” inadvertently voiced by many girls who will be surrendering their babies, should give us pause as to its implications regarding their efforts to prepare for the interruption of a biological process which does not readily lend itself to alteration by social stricture.

For most unmarried mothers this is a first experience in motherhood and as such

it may be an important influence in the image a girl establishes of herself as a mother-person. Part of our goal should be to help her emerge from it with as positive an image of herself as a mother as her personality and circumstances will permit. To do this we need to be ready, at appropriate points, to de-emphasize the unmarried, socially deviant aspect of her experience and accentuate its normal motherhood components. In fact we may well ask ourselves whether, in failing to exploit the full possibilities of motherhood for the unmarried mother, we may not be encouraging the blocking out of large areas of affect in her experience in maternity, whether she is surrendering her baby or keeping it.

In general, it might be well to examine our uncritical assumption that for the mother who must relinquish her child early separation is invariably indicated. Perhaps we need to consider the possibility that there are differences in the rates at which biological ties between mothers and babies are loosened, just as there are differences in the strength of these ties; that variations in the timing of the separation may therefore be indicated; that a premature separation may be as injurious as indefinite temporizing; and that perhaps the community has a responsibility to furnish the resources whereby such individual differences can be provided for.

If we see illegitimate pregnancy primarily as a symptom of underlying emotional pathology, we are likely to interpret much of an unmarried mother's behavior in similar terms. We will be on the alert for signs of pathology and will undoubtedly find them; one wonders whether we may not sometimes even be guilty of promoting the “self-fulfilling prophecy.”¹³ In trying to assess the nature and degree of disturbance, no matter how skillfully we proceed we may turn valid exploration into inappropriate probing, and find ourselves contributing to

¹³ Robert K. Merton, *Social Theory and Social Structure* (Glencoe, Ill.: The Free Press, 1957), pp. 421-426.

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the very disturbance we are trying to diagnose.

The extent to which pathology orientation can skew our thinking can be illustrated in two fairly typical experiences we are likely to meet in our work with unmarried mothers, namely, "denial" and planning for the baby.

DENIAL

The unmarried mother's use of "denial" is a source of some concern to social workers. We tend to see it in her efforts to delay her admission to the maternity home, in her remaining in ordinary clothing beyond the appropriate time, in her reluctance to discuss plans for the baby just yet, in her unwillingness to talk. This may well be a denial of sorts, but is it bad?

Unless a girl is seriously disturbed, it is a fairly safe guess that she is not denying to herself the *fact* of her pregnancy. The question then is, what is she denying, and to whom? Is she expressing the feeble hope that there may have been an error in diagnosis after all (a not uncommon reaction in married women), or could she be trying to minimize the implications of her abandonment by the baby's father? She may be struggling with the problem of maternal affect, seeking to protect herself psychologically from a growing interest in a baby she may have to give up.

In assessing the meaning of denial it might be well to take cognizance of our own role in fostering it. As agents of the community, we offer the unmarried pregnant girl anonymity in a protected shelter; we provide out-of-town mailing addresses; we encourage her to deny her maternity by plans for the early placement of her baby, so that she can resume her place in the community as though nothing had happened. What we interpret as pathology may be the girl's valid use of a healthy mechanism to protect herself in crisis from a threatening reality. She is behaving the way society requires, in order to avoid permanent im-

pairment of her social functioning. There are times when the girl who does not deny should perhaps be of greater concern to us than the one who does.

PLANNING FOR THE BABY

Our assumption that illegitimate pregnancy is invariably rooted in personality pathology has led us to accept uncritically certain further assumptions deriving from the basic one, namely:

1. That the same neurotic conflict which resulted in the out-of-wedlock pregnancy will motivate the girl in planning for her baby.

Her decision about the baby is based not upon her feeling for him as a separate individual but upon the purpose for which she bore him.¹⁴

2. That adoption is the preferred plan for the babies of unmarried mothers.

It is not an unwarranted interference with the unmarried mother to presume that in most cases it will be in the child's best interests for her to release her child for adoption. . . . The concept that the unmarried mother and her child constitute a family is to me unsupportable.¹⁵

3. That the girl who relinquishes her baby is healthier than the one who keeps hers.

No doubt many girls who should be relinquishing their babies are keeping them. Conversely, it may well be that some girls who are relinquishing their babies should keep them. One mother may be giving up her baby for reasons as neurotic as another's who keeps hers. However, if we are committed uncritically to the assumptions outlined here, we are less likely to give the adoption plan the thorough-going exploration that we devote to the plan to keep the baby, nor are we likely to examine the

¹⁴ Leontine Young, *op. cit.*, p. 199.

¹⁵ Joseph H. Reid, "Principles, Values, and Assumptions Underlying Adoption Practice," *Social Work*, Vol. 2, No. 1 (January 1957), p. 27.

extent to which factors in the girl and in society are responsible for making one plan more desirable than another.

Actually we do not have enough verified data regarding the long-range outcomes of either plan to substantiate one assumption over the other. In the meantime we are subscribing to a point of view which states in effect that the presence of neurotic conflict automatically cancels out the validity of an impulse which is biologically determined. A mother, married or unmarried, may be severely neurotic in her motivation toward motherhood and still be substantially maternal. If we fail to take cognizance of this, we are taking only a partial view of the problem and are likely to give the unwed mother an incomplete or distorted service in the various aspects of her problem.

Technically we may claim that our underlying point of view does not influence us and that each girl is allowed to make her own decision regarding her baby. And technically this is probably correct in most cases. But the subtle communication of our essential attitude cannot be denied—as observed by one girl who felt she was being pressured into surrendering her baby: "It's not what Mrs. K says exactly, it's just that her face lights up when I talk about adoption the way it doesn't when I talk about keeping Beth."

SUMMARY

In our emphasis on a single theory of causation with regard to unmarried motherhood we are overlooking other important aspects of this phenomenon. At a result we may be depriving ourselves of meaningful diagnostic perceptions and failing to make full use of the rich treatment possibilities inherent in the experience for the girl. The

additional factors of social mores, crisis, and the specifics of pregnancy and motherhood are offered for consideration here. They are presented not as substitutes for the currently accepted theory of underlying emotional conflict as causative in out-of-wedlock pregnancy, but rather as added dimensions which can extend our horizons and increase the effectiveness of our work in this area. Nor are these factors thought of as relevant for all unmarried mothers. It is hoped that they may be evaluated and applied with the same diagnostic discrimination, and on as individual a basis, as any theory.

If we are to help the unmarried pregnant woman to weather her experience with a minimum of damage, and if possible exploit it as a point of departure for her maturing as a woman, we must help her understand what is happening to her in terms of her personal psychological make-up, her biological experience, and the social world of which she is a part. To do this we must be ready to accept multiple theories of causation; we need to explore without bias as many of the relevant ingredients as we can identify, and bring them all to bear in our effort to understand and help her. We must be ready to divest ourselves of some of the stereotyped images of the unmarried mother to which we have uncritically committed ourselves, and to recognize the conflicts in our own roles as social workers in relation to this problem.

We need to search for ways of broadening our knowledge and applying it more meaningfully in diagnosis and treatment of the unmarried mother. We need to think in terms of hypotheses to be truly tested rather than closed systems of explanation for which we are impelled to find substantiating evidence.

BY JEANNE CAUGHLAN

Psychic Hazards of Unwed Paternity

FATHERHOOD CAN HAPPEN to men of all personality types and diagnostic categories, if they meet minimum requirements of age and initiative. Little has been written about fatherhood in general and less is known about the subgroup of the unwed; furthermore, it seems unlikely that we will obtain comprehensive data on this or the related subject of abortion as long as both are unmentionable subjects. There are, however, at least two reasons for supposing that qualifications for licensed and unlicensed parenthood are equally unselective, and that men with all kinds and degrees of pathology are eligible.

First, clinical experience in general does not support the hope—born of our need for certainty—that any symptom, symbol, or act has an absolute meaning. The personality of the ulcer patient cannot be predicted from the sore in his stomach, the snake does not always mean what we think, the act which initiates paternity may signify nothing more than a witless discharge of physiological tension—and nothing less than the fullest expression of the most mature relationship.

Second, we have clinical experience with this subject, although we lack research data, and it suggests that unwed fathers defy categories as stubbornly as do other groups. A great variety of psychosocial predisposing and precipitating factors can lead to the onset of this condition.

Perhaps it would be well to define the

term "clinical experience." For the purposes of this paper, it means primarily the experience of learning from patients in psychotherapy who have been fathers, both wed and unwed, and who have spoken in treatment hours about their subjective reactions to this event. Most of them have been veterans in treatment in VA neuropsychiatric services. Another group were soldiers in peacetime service, studied by James L. Curtis.¹ His research included married and unmarried fathers, classified in three groups: normal, men with minor psychiatric disturbance, and the severely ill. Symptoms were precipitated by the mate's pregnancy in both of the second groups. The ten unwed fathers were equally divided between health and sickness. In addition, information has come from patients whose therapists have doubled as their reporters.²

Foregoing comments about the heterogeneity of unwed fathers are not building up to such a truism as "study the individual case." They are meant as an invitation to set aside the "personality profile" approach for the moment and consider another perspective. It is the concept of stress.³ This

¹ James L. Curtis, "A Psychiatric Study of Expectant Fathers," *U.S. Armed Forces Medical Journal*, Vol. 6, No. 7 (July 1955), pp. 937-950.

² Therese Benedeck, *Insight and Personality Adjustment: A Study of the Psychological Effects of War* (New York: Ronald Press Co., 1946), pp. 100-239; Edith Jacobson, M.D., "Development of the Wish for a Child in Boys," *Psychoanalytic Study of the Child*, Vol. 5 (1950), pp. 139-152; Norman Reider, M.D., "The Unmarried Father," *American Journal of Orthopsychiatry*, Vol. 18, No. 2 (April 1948), pp. 230-237.

³ Irene M. Josselyn, M.D., "Psychology of Fatherliness," *Smith College Studies in Social Work*, Vol. 26, No. 2 (February 1956), pp. 1-12.

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suggests a possible framework for study, in the form of a chain of hypotheses.

First, expectant fatherhood is a stress situation with a characteristic form; therefore it confronts all subjects with a common core of psychological problems. However, their impact varies from mild stimulation to severe trauma. Hence a second hypothesis: the variable factor is degree of stress. Any or all of the forces to which a bio-psychosocial being is subject may contribute to stress. Especially pertinent factors are these: the nature and outcome of each man's previous struggles with similar problems, notably dilemmas of childhood; the relationship with the unwed mother; family, social, and economic pressures. The final hypothesis is that each man reacts to the situation with his favorite modes of dealing with stress, using everyday defenses when pressure is mild and resorting to more and more drastic measures as it mounts.

It would be gratuitous to inform social workers that reality is important. Therefore I shall jump into the middle of the second hypothesis to dispose of the outside world with just a few comments about extrapsychic contributors to stress.

STRESS—EXTERNAL FORCES

Parenthood is known to be the outcome of an interaction between two people. In order to understand the etiology of any particular instance of parenthood, it is therefore necessary to consider each participant plus the relationship. Unwed mothers have been favored with much concern, and it is good to have this opportunity to give their mates some attention. Before doing so, I wish to propose future study addressed to the subject of the unwed couple. This is easier to recommend than to accomplish—sometimes one of the couple cannot be found! However, clues to the relationship are available even when only one-half of the couple is seen.

Pertinent questions are these: What is each person seeking? What conscious and unconscious needs does he hope the partner

will meet? The sexual act can, of course, represent an attempt to reach many goals other than genital sexual fulfillment. What roles has each member assigned to the other in the fantasied story of his own life which he seeks to recreate in real life? What happens when the aims of both people coincide—or collide? Such questions must be considered over and over; actual changes occur as long as the relationship lasts, and fantasy changes are possible as long as it is remembered.

For example, two high school students formed a casual alliance in the form of occasional dates with no promises exchanged. Some of their unconscious emotional transactions went like this. For the girl, the boy was one of several pawns whom she used in a defiant, teasing game with her mother. For the boy, she was a worldly woman with whom he could try out being a man of the world. Her pregnancy seemed to intensify her absorption in her mother, and when he had done his financial duty he considered that his function was finished and he was excused. However, his leaving changed him from a passive pawn to an active deserter. As a symbol of her deserting father, he became a significant person for her, and she launched a campaign to punish and win him back, simultaneously, via marriage. He was surprised and protested, "Why me?" His counter-reaction, which she interpreted as callous rejection, served to reconfirm her long-standing suspicion that men are beasts.

Of the many societal influences on unwed parents, these two are of special interest: First, it is a curious fact that the fatherhood has received almost unanimous inattention from the behavioral sciences. Men have been studied and treated, for the most part, without particular attention to their fatherliness. This scientific disinterest is consistent with Irene Josselyn's observation that society tends to ignore or make fun of the male as parent. She fears that fatherhood is a declining and devalued role.⁴ The

⁴ Hans Selye, *Stress* (Montreal, Canada: Acts, Inc., 1950).

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implication for unwed fathers is clear: if paternity offers many burdens and few rewards, it scarcely seems worth while to legitimize their state. Jokes about fatherhood often hint that the wise man is one who doesn't get caught.

Second is illegitimacy itself. Of the many socioeconomic problems which may confront prospective parents, it is the most conspicuous. However, its capacity to create stress is quite variable. Subgroups within the larger society attach different degrees of significance to civil or religious sanctions for mating; illegitimate conception is therefore a more or less heinous offense. Furthermore, all groups attach different degrees of shame and blame according to the status and vocation of the offender. However, the degree of stress probably depends more on the unwed parents' resources for solving the problem than on the problem *per se*.

Illegitimacy is not notably disruptive for many couples. It is an open secret that weddings are not infrequently followed by births which are called premature, and which are indeed premature socially, if not physiologically. Such belatedly solemnized unions can turn out well. Such parents usually do not become patients, hence they elude scientific observation. However, they have obviously possessed the advantage of being legally free to marry. Their functioning suggests that they were ready for marriage and parenthood, and willing to undertake these relationships with each other, when the time for action arrived.

There is an abundance of clinical proof that approaching parenthood can be as traumatic for the married as for the unmarried, and that the reasons for stress may be identical. Lack of money can create realistic anxiety. Parenthood may be a frightening prospect if the parent is chronologically or psychiatrically immature or physically ill, even if the relationship with the other parent is sound. Conversely, the relationship can be the source of alarm: people who find themselves mismated may be individually capable of parenthood, but reluc-

tant to undertake it with each other.

Such feelings have nothing to do with legitimacy. However, legal status does determine the kinds of action which their possessors can take to resolve them. One important difference between licit and illicit unions is the procedure for termination. Dissolution of a public marriage contract sealed by church and state is either complicated or impossible. A private union can be terminated by either parent with no more formality than the act of going away.

PSYCHIC HAZARDS

Now, turning from external to internal, let us consider the psychological hazards in greater detail. Of course they are not really separable, like a row of hurdles in an obstacle race; but analysis necessitates artificial divisions. The reader will realize, too, that the case illustrations are oversimplified, and that many other factors were operative in each situation. The point is simply that the factor in question was a significant one.

Expectant paternity is first of all a test of ego strength. Self-doubt and fear of being found wanting are normal for the man about to assume this responsible role; their absence suggests strenuous defensive maneuvers or serious failure in development. This anxiety spawns regressive wishes to call it all off. Men lacking in ego strength, through youth or illness, may respond with impulsive behavior—such as getting out of town—or resort to physical or psychiatric illness and hospitalization.

One married patient expressed this self-distrust with memorable poignancy. He was schizophrenic, *i.e.*, seriously lacking in ego strength, but he also lacked even the dubious consolation of delusions or projections, and his insight was painfully keen. His marital and economic situation was stable; his psychiatric condition was chronic and clearly "ambulatory," except when his wife became pregnant. All the usual tasks and concerns of that period were magnified to overwhelming proportions by his in-

ability to cope with them and the self-hatred stirred up by this weakness. He dreaded the moment when labor began and he would prove unable to take his wife to the hospital a few blocks away.

However, the thought of a baby, helpless and dependent on him, aroused the height of terror. He would fail his son as his own father had failed him. His son would therefore grow up psychotic and fail his son, and so on for generations, in endless perseveration of his own tragic childhood. Such preoccupations resulted in acute, suicidal depression and hospitalization prior to each of the first two births. Daily interviews, in part psychotherapy and in part instruction on how to be a father in relation to each task of the day, enabled him to care for the older children while the third baby arrived.

Curtis' findings remind us that men often equate ego strength and virility. His normal subjects produced fantasies of male courage and prowess in response to projective tests; if they had a counterphobic ring, bravado is no mean asset at times. Sicker men often portrayed weak, inept heroes who were unable to cope with a complex plot.

Concern about masculinity is generally intermingled with feelings about the father whose role the man is about to assume. His success in this venture is better assured if he has resolved those feelings in positive identification with the father. As the above-mentioned patient remarked, he did not know how to be a good father because he had never known one. However, Oedipal conflicts are so well understood, and their impact on this situation so apparent, that one comment will not be out of place. A "shotgun wedding" is the classic punishment for the unlicensed pretender to the paternal throne. The moral seems clear: if a boy plays forbidden games with his toy pistol, someone's dad retaliates with a dangerous gun!

Pregenital conflicts are aroused, too; among them envy of feminine reproductive

power. People want everything—each sex envies the talent of the other; boys want to have babies. This wish develops concurrently with curiosity about sexual functioning in general, and is associated with childish theories about the birth process. It is under taboo in our culture; nevertheless it is suggested by common expressions. Men give birth to projects and call their creations their babies. Little boys, who have not yet learned that the wish is unmanly, sometimes "play pregnant" with the aid of a pillow.

Other civilizations are franker. Consider the widespread popularity of the *couvade* or the secrets of tribal men's societies—prohibited to females on pain of death, and stolen from women by some departed hero. The Greeks maintained that the father-god can succeed where mortals fail. Zeus became intolerably exasperated by his wife's superior wisdom just after she became pregnant, so he swallowed her and in due time gave birth to Athena through his forehead.

It seems that even Zeus lacked the secrets of conception and delivery, but his introjective feat did succeed in punishing and replacing his woman simultaneously. Mortals can attempt the same action on a humbler scale. Edith Jacobson reports the psychoanalysis of a man whose illicit amours followed the Don Juan pattern of seduction-desertion and resulted in several illegitimate births. One determinant of this spiteful behavior appeared when his first legitimate child was born: he campaigned fiercely for each aspect of the maternal role, declaring that he was the superior mother.

Another source of stress is that enviable creature, the baby. His privileges include attention, dependency, unrestrained impulsiveness, unabashed narcissism, plus the libidinal pleasures of being inside the mother, nursing, and being coddled. Longing for these privileges persists, however quiescent, in everyone who was ever a baby; contact with an infant reactivates it. Not only siblings experience sibling rivalry.

Social Work

Psychic Hazards of Unwed Paternity

DEALING WITH STRESS

The father is handicapped in dealing with these longings. He is forbidden to have them. Society defines masculine dependency as unmanly, passive yearnings as downright "queer." He is likely to concur, and try to exclude them from consciousness. This effort is required at a time when he is deprived of at least some of the libidinal gratification which his mate has provided.

Another schizophrenic patient dramatized these regressive wishes. He could not discuss them, because he was unaware of them when he could talk. At times of remission he was emphatically adult, responsible, and controlled. At times of illness he crawled into a crib, became mute and regressed, and required the total care of an infant. These acute episodes occurred when his wife was pregnant.

Increased drinking occurred among all fathers studied by Curtis, a fact which will not amaze family caseworkers. Alcohol can drown any trouble, but it is likely that oral and genital frustration, in deadly alliance, can impel men to seek consolation in the bar with "the boys" and the bottle. Extra-marital affairs are another resource, even among men who are otherwise faithful.

Frequent gastrointestinal symptoms and a newly developed ulcer were also observed by Curtis. The gastrointestinal system can, like drinking, signal anxiety for any reason, but oral deprivation is known to be one possible meaning. A patient whose ulcer arrived with his wife's pregnancy jokingly called it his baby; when pains occurred, he said the baby was hungry. Exploration of these comments, plus other information revealed in his treatment, suggested that this was a dual-purpose symptom; it expressed the wish to have a baby plus the wish to be one. He was both mother and child.

Another major hazard is the peripheral role which biology assigns to the expectant father. This is often perceived as a privilege by the female, and it does indeed facili-

tate escape. However, it is not altogether rewarding to be an outsider, the third person in the prenatal trinity. A man cannot easily relate to an unborn child. It is an idea more than a baby. Unless the mother is exceedingly good at denial, the baby is for her a real presence, experienced physiologically. It is normal for her to be absorbed in the mother-child symbiosis which he cannot share.

Most importantly, the very fact of fatherhood must be taken on faith. It has been said—though the name of the speaker does not come to mind—that the Mona Lisa smiles because she alone *knows*. Faith in their fatherhood comes hard for some men. Sometimes, of course, the mate is not reliable. However, men can have unjustified suspicions, too.

A man who was immature but not ordinarily psychotic developed paranoid delusions about his wife's infidelity each time she was pregnant, but accepted the babies once they were born. The homosexual component of such ideas may well have been present, but another factor—distrust—was outstanding. He doubted his wife because she was actually both bright and manipulative. He doubted himself even more, and felt impotent to instigate pregnancy. Therefore it had to be some other man.

Projection is of course everyone's favorite device for warding off guilt and responsibility. This may be one cause for the prevalence of such suspicion among unwed parents who are no more paranoid than all humans. However, there are also cultural reasons. Legal marriage promises permanency and protection from rivals, while the unwed lack such assurance. Besides, they can scarcely escape the double standard of society, from which the proposition is derived, "She made it with me, so she will with everyone else." This idea derogates the woman, but also the man, since it denies him any special appeal—hence it may be that culture serves to reinforce the self-doubt mentioned above.

One patient, for instance, was normal-neurotic, inclined to introject rather than project, and lacking in self-esteem, *i.e.*, his character was depressive. His relationship with his mate was time-tested and the marriage planned before he proposed sexual consummation, while further time was required to resolve her moral concerns. Immediately afterward he experienced admittedly senseless torment about her fidelity. He had never consciously subscribed to the idea that "a girl who gave in was not to be trusted," but there it was. He discovered that this suspicion represented childhood instruction plus his lifelong conviction that no woman could prefer him. His insight and the girl's steady affection enabled him to transcend the doubt, but it persisted until they were married by law.

The problem of guilt can arise in or out of wedlock, but it is most crucial for the unwed. Realistic or actual guilt is appropriate for people who break laws and its absence a sign of pathology in the relationship, or in the parent's development, or else a sign of busy defenses.

An unmarried patient took a flatly doing-nothing stand (or *sit*) with regard to his mate's pregnancy. He contributed heavily to her final decision—abortion—by offering only that amount of money. Nevertheless he felt innocent, a remarkable feat for a man who was neither psychotic nor impulsive, but rather conventional, deliberate, somewhat compulsive, and a devout Catholic. It was achievable because the relationship had a mother-child quality. At work she was his boss, at home she cared for him—sometimes it seemed as though he made love in gratitude for her good dinners. He believed that the child in such a relationship bore no responsibility; therefore the guilt was totally hers.

Excessive guilt or remorse suggests a fantasy offense as well as the real one. Someone must have been injured. It is no news that depression often relates to aggression, and that the male sexual role is aggressive. Attacking and conquering im-

pulses are probably omnipresent, even when fused with and subdued by libido. Besides, some hostility is provoked by every close relationship. Therefore, if a man is intolerant of these aggressive feelings, he need not have been more than normally hostile to feel as though he had inflicted attack.

Depressions were frequent symptoms among sick fathers in Curtis' study, and a suicidal attempt occurred after an illicit pregnancy terminated by miscarriage or abortion. Guilt is a probable factor in the latter case, a possible one in the others.

The last cause for stress which I will mention is fear of being trapped. Men usually dispose of it at the time of marriage, but an unhappily married father may feel that pregnancy is planned to prevent his escape. An unmarried man is almost certain to consider that this may be designed to force marriage. The suspicion may be correct in either case. However, it may also be based on a lifelong conviction that women are possessive and overpowering, or a lifelong tendency to feel confined by any close relationship.

A paranoid patient lived for years in a common-law relationship, an apparently settled husband and father. He could not legalize the marriage because it would be like a hospital closed ward, an intolerable trap. An unmarried father reported by Curtis developed ulcerative colitis soon after a shotgun wedding. Stress is caused by problems, cured by pleasure. Great effort it undertaken willingly if the goal is highly valued; minor discomfort is intolerable if it promises no return. The final determinant of level of stress is the degree to which it is balanced by rewards.

Society, in the person of its immediate representatives (including caseworker or therapist), can recognize the dignity of the father's role or ignore it. The mate can increase his faith in his potential fatherliness, or indicate that he will never be much of a man. She can mother him in many acceptable ways (just as she hopes he will "father" her) and include him in

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the experience of the baby inside her. The father who is invited to "feel how the baby kicks!" can begin at that moment to relate to his child. On the other hand, the mother can shut him out.

Fatherhood offers not only intrapsychic conflicts, but also intrapsychic rewards. The man who does not take any pride in proven virility and delight in catching up with his father is sick indeed. Fatherhood can be a positive aim and ego ideal, and a man can anticipate reliving his childhood in identification with his child. The man who hopes for a son whom he can teach to play baseball has two motives, both good!

SUMMARY

There is evidence that unwed fathers possess all personality types and fall into all diagnostic categories. Furthermore, the situation of unwed paternity takes many forms, depending on the character of both partici-

pants, their relationship with each other, and many socioeconomic factors in addition to illegitimacy.

Psychoanalytic theory is valuable for formulating the intrapsychic conflicts of the parents and some aspects of their relationship. However, sociological and legal considerations are pertinent, too, and economics will be important as long as babies take money.

The concept of stress is proposed as a framework for understanding the situation of unwed parenthood in all its multifaceted complexity. Three hypotheses derived from it have been stated here and tried out with reference to fathers. If they have value, they can be restated in feminine terms. However, if fathers and mothers were as separate in fact as they are in studies similar to this one, parenthood would not occur. One is led to hope that future studies will consider unwed parenthood as a relationship: two people plus interaction.

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BY EDMOND F. SASSIN AND MICHAEL H. DALTON

Recognition of Organic Factors in Behavior Disorders

IN RECENT YEARS, increasing attention has been devoted to the study and treatment of behavior disorders that arise from structural changes in the brain due to various kinds of trauma. The authors believe that such conditions are far more common in the etiology of behavior disorders than is generally realized. The present article discusses the value of a team approach between the neuropsychiatrist and the social worker in the diagnosis and treatment of such conditions, and especially the contribution that the social caseworker in the nonmedical setting can make as a case-finder. The social history can be a valuable diagnostic aid in the recognition of organic factors in the etiology of behavior disorders.

The social histories of such patients reveal certain typical patterns which give them unusual diagnostic value. The social worker who participates in the study of such cases should begin by evaluating the personalities of the patient's mother and father to determine whether they exhibit any substantial signs of abnormality; he should also learn what their attitudes and feelings are toward the child and how they

have handled him. If the personalities of the parents and their behavior toward the child do not show any obvious abnormality, the presence of an organic factor should be suspected. In evaluating parents, one must keep in mind that there is no parent who cannot be accused of a variety of minor quirks and occasional mishandling of his children. If the parents are to be considered the cause of the child's troubles, then the abnormalities in the parents' personalities and behavior must be sufficiently severe and extensive to have caused the type and severity of behavior observed in the child. Tec has used this same principle in evaluating child schizophrenics to distinguish between those whose schizophrenia is on an environmental basis and those in which it apparently has more of a constitutional basis. Observing that some seriously sick children have warm and intelligent parents, he interpreted this obvious lack of severe environmental trauma as indicative of a strong constitutional factor.¹

If the patient has siblings—and most do—this circumstance can be very helpful in diagnosis. If the patient's siblings are all reasonably well-behaved and making successful adjustments, this fact suggests that the patient's environment has been satisfactory and that his behavior probably stems from some organic defect within himself. People have always been aware of the occasional presence of a "black sheep" in an otherwise normal family. Probably many of the "black sheep" are organic cases. When this type of picture is encountered,

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¹ Leon Tec, M.D., "Vicissitudes in Guidance of Parents of Schizophrenic Children," *Journal of Nervous and Mental Disease*, Vol. 124, No. 3 (September 1956), p. 233.

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some practitioners tend to assume that the parents in some obscure way must have rejected the patient or treated him differently. Unless there is sufficient objective evidence of such a rejection by the parent, one does violence to science to assume that it exists. The authors have always found it hard to believe that a parent who is so warped that he rejects one of his children severely could at the same time rear his other children with appropriate love and affection. Tec expresses a similar opinion in regard to schizophrenic children.² While he recognizes that no two children are ever born into exactly the same environment, he finds it difficult to believe that parents could be "schizophrenogenic" to one child only, and therefore considers the presence of normal siblings in the family of a schizophrenic child as evidence that the condition may be primarily on a constitutional basis.

POSSIBLE CLUES

The response of the child's behavior to handling can be a clue. If it is of environmental origin, it will frequently show favorable response to efforts by therapists, parents, teachers, clergy, and so on, to correct it. On the other hand, if no method of handling ever seems to have a beneficial effect on the behavior, this suggests the presence of a physical condition which prevents these various therapeutic efforts from having any effect. Aird and Tsubaki, for instance, express the opinion that the use of psychotherapeutic methods alone is generally ineffectual in the treatment of behavior disorders that have their origin in temporal lobe pathology.³

The type of behavior is quite significant. Violent temper, low frustration tolerance, irritability, hyperactivity, and hypersensitivity make up a syndrome which frequently

turns out to be organic. There may be disturbed sleep, enuresis, or speech difficulties. Sometimes poor motor co-ordination and impulsive behavior occur, with a consequent accident-proneness. This is the behavior syndrome, once called the "epileptic personality," which in later years has been considered to be associated for the most part with temporal lobe lesions.⁴

The social worker should inquire into the hereditary background of the patient, particularly as to whether there are any relatives who have convulsions, violent temper, criminality, or sociopathic behavior. Knott *et al.* believe that the abnormal electroencephalograms found in behavior disorders have a genetic component; this is based on their examination of the electroencephalograms of the parents of children with behavior problems.⁵ Lennox *et al.* express the belief that the electroencephalographic pattern is hereditary.⁶ Also, their research shows that patients whose seizures began subsequent to an injury to the brain which occurred before they reached adulthood have three times as many relatives with seizures as do persons in the general population.⁷ The implication is that the individual who has inherited an abnormal electroencephalographic pattern is more likely to develop symptoms if he suffers a trauma to the brain (before reaching adulthood) than is an individual who has inherited a normal electroencephalographic pattern.

The social worker can easily obtain information which suggests a possible brain

⁴ *Ibid.*, p. 403.

⁵ J. R. Knott, E. B. Platt, A. Coulson, and J. S. Gottlieb, "A Familial Evaluation of the Electroencephalogram of Patients with Primary Behavior Disorder and Psychopathic Personality," *Electroencephalography and Clinical Neurophysiology*, Vol. 5, No. 3 (August 1953), p. 369.

⁶ W. G. Lennox, M.D., E. L. Gibbs, and F. A. Gibbs, M.D., "Twins, Brain Waves and Epilepsy," *Journal of Nervous and Mental Disease*, Vol. 95, No. 3 (March 1942), p. 355.

⁷ W. G. Lennox, M.D., E. L. Gibbs, and F. A. Gibbs, M.D., "Inheritance of Cerebral Dysrhythmia and Epilepsy," *Archives of Neurology and Psychiatry*, Vol. 44, No. 6 (December 1940), pp. 1176-1177.

² *Ibid.*, p. 235.

³ Robert B. Aird and Tadao Tsubaki, "Common Sources of Error in the Diagnosis and Treatment of Convulsive Disorders: A Review of 204 Patients with Temporal Lobe Epilepsy," *Journal of Nervous and Mental Disease*, Vol. 127, No. 5 (November 1958), p. 402.

injury. Some difficulties of birth, such as the use of forceps, a prolonged labor, or a very short labor and fast delivery, sometimes cause a brain injury. Children so damaged are frequently irritable and hyperactive practically from the day of birth. Earle *et al.* have demonstrated the manner in which injury to the brain can occur from herniation of a part of the temporal lobe by birth compression.⁸ Accidents involving blows to the head which are followed by unconsciousness or vomiting should be reported. A high fever, particularly one which is associated with convulsions, may indicate an encephalitis. Sometimes there will be a history of convulsions or epileptiform episodes. If the patient received medical care in connection with these incidents or illnesses, it may be possible to obtain more detailed information from the physician who treated him or from the medical record librarian, if he was hospitalized.

MEDICAL REFERRAL AND TREATMENT

If the social history of a patient with violent temper, uncontrollable behavior, hyperactivity, hypersensitivity, and so forth, reveals essentially normal parents and siblings, plus information suggesting a possible brain injury, the social worker's report to the neuropsychiatric member of the team should call attention to this fact and suggest that the comparative lack of pathology in the patient's social background implies that the possible presence of organic factors should be investigated medically. If the social worker is practicing in a nonmedical setting, he should refer the patient to the appropriate medical specialist, usually a neuropsychiatrist.⁹ In many cases with this type

of social history, the neuropsychiatrist will diagnose the behavior as organic. The neurological examination usually shows little or no abnormality. However, some of these cases will show organicity in the psychological testing, and most will have abnormal electroencephalograms.

Numerous practitioners have reported success in treating this type of organic behavior with the same kinds of medicines that are used in the treatment of epilepsy.¹⁰ In addition, Levy has recently reported very good therapeutic results from the use of an amphetamine, benzedrine sulfate.¹¹ The authors have generally found the hydantoins effective in the treatment of this kind of case. Most patients will show a substantial degree of improvement, and a few will achieve practically a complete recovery.

Initially, usually within a period of a few days, there will be a somewhat sudden and dramatic improvement in the basic symptoms of violence, temper, and so on. Following this, there will be a further but gradual improvement in the patient's overall adjustment which occurs because of the patient's improved ability to relate to his environment. The environment reacts toward the improved patient in a more friendly manner, and the efforts of parents, teachers, and caseworkers are now more effective. Some patients show an improvement in intellectual functioning which may reflect improved cortical organization produced by the medication.

For the patient who shows little or no improvement, further study is needed to see whether some of the newer drugs developed for the treatment of temporal lobe epilepsy will help. Aird and Tsubaki report con-

⁸ K. M. Earle, M. Baldwin, and W. Penfield, "Incisural Sclerosis and Temporal Lobe Seizures Produced by Hippocampal Herniation at Birth," *Archives of Neurology and Psychiatry*, Vol. 69, No. 1 (January 1953), p. 39.

⁹ If the social worker is doubtful as to whether the client needs to be referred to a neuropsychiatrist, it would seem that in fairness to the client he should be referred since other diagnostic techniques may clarify the matter.

¹⁰ Aird and Tsubaki, *op. cit.*; George C. Sisler, Lewis L. Levy, and Ephraim Roseman, "Epilepsia Cursiva—Syndrome of Running Fits," *Archives of Neurology and Psychiatry*, Vol. 69, No. 1 (January 1953), p. 79; Esther Bogen Tietz, "The Use of Medicine in the Behavior Disorders," *Medical Woman's Journal*, Vol. 53, No. 8 (August 1946), p. 18.

¹¹ Sol Levy, "Post-encephalitic Behavior Disorder—a Forgotten Entity: A Report of 100 Cases," *American Journal of Psychiatry*, Vol. 115, No. 12 (June 1959), p. 1064.

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siderable success in treating those who previously had not responded to conventional anticonvulsants.¹² If none of these help, the case can be reviewed by a neurosurgeon to see if operative procedures are indicated.

SOCIAL WORKER'S CONTRIBUTION

The authors have found the social history to be a valuable diagnostic aid in the evaluation of patients with possible organic factors. In most cases, the social history contributes substantially to the final diagnosis, and in an occasional case it can be the deciding factor. It sometimes happens that the results of the neurological examination and electroencephalogram are nondiagnostic, while the social history clearly reveals a picture of satisfactory parents and adequate siblings in contrast to a patient who has the typical problem behavior seen in organic syndromes. In such cases, final decision in regard to diagnosis may be made only after a trial period of medication.

The social worker can render an even greater service as a case-finder. It is important to recall that the majority of social workers practice in nonmedical settings such as family and children's agencies, welfare agencies, juvenile courts, recreation agencies, schools, or the like. Children with aggressive, delinquent behavior are frequently referred to social workers. Many such children do not come to the attention of a physician; this is especially likely to be the case in children who have organic behavior without frank convulsive phenomena. If the social worker knows how to recognize cases which may be on an organic basis, he can refer such children to the appropriate medical specialist. As Levy points out, there is good reason to believe that many children who are labeled as juvenile delinquents are in fact suffering from an unrecognized organic brain disorder.¹³

One must keep in mind that there is a definite advantage in recognizing such cases

at an early age. If such an organic behavior condition continues for long without adequate drug therapy, serious secondary complications inevitably result.¹⁴ The child who displays aggressive, violent behavior invites retaliation from the environment in the form of rebukes and punitive retribution. Children dislike and shun him, while teachers and neighbors frequently complain to his parents. School work is impaired, and as the years pass the child is increasingly marked with the stigmata of the anti-social, delinquent child. The child becomes bitter, suspicious, cynical, resentful, and hardened. Adequate medical treatment can correct the primary difficulty and—if given in time—can prevent the development of these secondary complications. Even if medical treatment is late, good results can still be achieved, although a longer period of social casework will be required to overcome the secondary complications which have developed.

SUMMARY

The contribution of the social history in the diagnosis of organic brain conditions has been reviewed. The social histories of organic patients usually follow a typical pattern, characterized by (1) the absence of any obvious abnormalities of personality or behavior in the parents; (2) the presence of normal, adequate siblings; (3) an aggressive, violent type of behavior in the patient, which does not respond to efforts of parents, teachers, or therapists to modify it; (4) a history of a possible brain injury from birth experience, accident, or encephalitis; and (5) a family background which suggests that there may be a hereditary dysrhythmia in the family tree. If all or most of these indicators are present, a neuropsychiatrist should examine the patient to determine if he has an organic brain syndrome. The treatment of such cases is reviewed. The role of the social caseworker in the nonmedical setting as a case-finder is emphasized.

¹² *Op. cit.*

¹³ Levy, *op. cit.*, p. 1065.

¹⁴ Aird and Tsubaki, *op. cit.*

BY GEORGE LEVINGER

Continuance in Casework and Other Helping Relationships: A Review of Current Research

IN RECENT YEARS there has been an increasing amount of research on the effectiveness of services offered by social agencies, clinics, and counseling centers. One major area of interest pertains to clients' likelihood of continuing, contrasted with their likelihood of discontinuing, treatment. Numerous studies have reported that client discontinuance of contact with the agency represents a large proportion of persons seen at intake. One recent study of over 1500 cases (38)¹ found this rate as high as 59 percent. Other studies have reported somewhat lower percentages, depending on their definition of discontinuance and on the agency population (16, 20, 30, 41).

Ripple has pointed out that "... 'con-

tinuance' is not synonymous with 'use' of casework service . . . however, continuance is the necessary antecedent to use of service" (25, p. 87). The continuance of clients at community agencies thus can be considered a problem for the community at large, for agency staff members, and for social researchers.

The study of client continuance is important for an additional reason. Continuance and discontinuance do not merely indicate the number of dropouts, but also can be evidence of success in establishing the client-worker relationship. Researchers who are concerned with judging "improvement" in treatment find it difficult to construct objective indices for demonstrating such a change. Even the studies of Hunt, Rogers, and their colleagues (14, 27) have served to raise more questions than they have answered about the adequate measurement of movement or of personality change. On the other hand, continuance can be measured objectively in terms of the number of interviews held; and the study of related factors seems a meaningful step in evaluating the effectiveness of casework or psychotherapy (cf. Herzog, 11).

One must note that continuance is not necessarily predictive of improvement. According to Blenkner (4) and Katz, Lorr, and Rubinstein (17), the variables which distinguish between continuers and discontinuers do not distinguish similarly between

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¹ Numbers in parentheses refer to the numbered references listed at the end.

Continuance in Casework: Review of Research

successful and unsuccessful cases. Persons staying a short time may "improve" more than those staying a long time. Yet "degree of success" can only be measured for those cases which continue contact with the agency, and discontinuers are automatically excluded from consideration in such samples.

The aim of this paper is to review the evidence pertaining to continuance in treatment. It does not confine itself to studies conducted by social workers or in social work settings, but includes the contributions by members of related fields—psychologists, psychiatrists, sociologists—who have also investigated the phenomenon, usually in outpatient clinics. The review attempts to integrate the findings from these rather diverse sources and to point out some gaps in our current knowledge.

The purpose is to find connections among studies from varying orientations. Therefore it is desirable to use a relatively neutral terminology which applies similarly to all the findings. The term *person* (P) will refer to client, patient, or counselee; *helper* (H) will refer to social worker, psychiatrist, therapist, or counselor. *Continuance* will mean P's remaining in a relationship with H for at least some minimum number of interviews. In some studies, continuance has meant staying merely beyond the first interview; in others, it has meant staying more than four or more than five interviews. *Discontinuance*, on the other hand, will mean leaving the relationship *before* the completion of such a minimal number of interviews.²

In choosing a framework for organizing various findings on continuance, one may

look for previous efforts in this direction. However, it appears that most writers have limited their attention to the particular variables which concerned them, rather than trying to outline encompassing schemes. Most of the work has taken its departure from empirical findings, rather than from theoretical presuppositions. This tendency is understandable, because researchers usually have been limited to the records of interviews or psychological tests obtained prior to their studies.

Several investigators have tried to offer the reader some general organizing frame. Among the social work studies, Ripple's research (24, 25, 26) has examined continuance as a function of four general variables: the client's motivation, his capacity, the opportunity afforded by his environment, and the opportunity afforded by the agency. Sullivan, Miller, and Smelser (34), in a study of outpatient psychotherapy, classified predictive factors into three groups: (a) characteristics of the patient, (b) characteristics of the therapist, and (c) situational variables. Finally, in a comprehensive review of "why patients leave psychotherapy," Frank and his associates (7) considered possible answers in terms of two general headings—personal attributes of patients and aspects of the treatment situation—under which they grouped further subheadings.

In the review that follows, the available data are considered in terms of a frame which summarizes the important factors affecting the person-helper relationship. The person's continuance or discontinuance is viewed as *behavior* in a situation inhabited by P and H. Thus, it is assumed that P's behavior depends on the characteristics of P, the characteristics of H, and the nature of the P-H relationship. And it is assumed that the behavior of both P and H is a function of their personalities and their environments.

It follows, then, that P's continuance in treatment is a function of variables in the following five areas: *P's personal attributes*, *P's current environment*, *H's personal at-*

² The studies to be reviewed differ in their definitions of continuance, an inescapable situation for this kind of integrative review. For reasons of space limitation, it is not possible to define "continuance" for each study to be cited. In general, the settings of the studies will be specified. Let us note in advance that they include family and children's agencies offering casework, adult and children's psychiatric clinics, and one marriage counseling agency.

tributes, *H's* current environment, and the characteristics of the *P-H* relationship.³

P'S PERSONAL ATTRIBUTES

P's Problem. This section reviews continuance in treatment as related to the nature of *P's* problem, his perception of it, and his motivation to deal with it. Let us start by examining the characteristics of their problems that may differentiate between continuers and discontinuers. Studying the intake population of a family agency, Blenkner (4) found that those individuals whose problems were primarily "psychological and interpersonal" were more likely to remain in casework service after a first interview than were those with other kinds of problems. In the same agency, Kogan (18) examined the characteristics of clients who discontinued contact after one interview, despite encouragement to continue, and compared them to those who "planned" their one-interview closing with the worker. According to the case records, the unplanned closers tended to have more complex problems than the planned closers.⁴

In a study of adolescent clients, Werble (39) found other pertinent differences between continuers and discontinuers. Continuers—those staying five or more interviews—presented "predominant problems" in any one of the following areas: malfunctioning in school; in community relations; in peer relations; or they saw the problem in themselves. On the other hand, discontinuers tended to report their problems as the malfunctioning of family relations or

as external to themselves, or else failed to recognize any problem at all.

In her study of social agency clients, Ripple (25) examined the relation between continuance and the client's discomfort with his problem.⁵ Although degree of discomfort was not necessarily related to continuance, those clients whose discomfort was low were unlikely to continue their interviews. Similar findings were reported by Werble.

In an adult psychiatric outpatient clinic, Frank and his associates (7) have reported that the length of stay in treatment is related positively to the duration of the illness. Furthermore, patients whose illnesses were "fluctuating" tended to remain in treatment significantly more often than those whose illnesses were "stationary."

Turning now to *P's perception* of his problems, the following studies can be reviewed. In a study at a children's psychiatric clinic, Lake (19) examined the application records of 100 families coming for treatment. Although all these families were asked to return after applying, 50 discontinued their contact. The continuers significantly more often considered their problems as arising within the family unit, whereas the discontinuers were more likely to blame the neighborhood or the outside community as being a source of their problems. Similarly, Kogan (18) found that the unplanned closers more frequently attributed responsibility to others than did the planned closers.

In a marital counseling agency, Mitchell, Preston, and Mudd (23) reported that the client who continued tended to give a less negative picture of his spouse; he also shared the blame for the problems, instead of attributing the fault entirely to spouse (or to self). While spouses of continuers may actually have been different from those of discontinuers, it is more likely that the clients' perceptions made the critical difference. Data from VA outpatient clinics seem to confirm these findings. Studies by Rubenstein and Lorr (28) and by Lorr,

³ One additional variable which might be included in the scheme is "time." This variable would refer to the history of the *P-H* relationship: What actions have preceded a given event? Is *P's* behavior occurring during the first, the fourth, or the fortieth interview? And so forth. In the present review, however, the time dimension of the *P-H* relationship will not be considered.

⁴ It should be noted that while the definition of "unplanned closer" is similar to that of discontinuer, the meaning of "planned closer" is not similarly parallel to that of continuer.

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Katz, and Rubinstein (21) showed that continuers were more willing to express dissatisfaction with themselves than were discontinuers.

It appears that in general discontinuers accept less responsibility for their problems than do continuers. The following hypothesis will bear further test: The more P sees his problem as internal rather than external, the more likely he is to continue treatment.

Regarding P's *motivation* to solve his problems, one can consider some studies in Ripple's research program. Ripple (25) has found that the client's "drive to solve the problem" is positively related to his likelihood of remaining in casework service. The same report notes that continuers have more hope than discontinuers of resolving the problems they perceive. Werble (39) has cited data from some unpublished studies confirming Ripple's reports. Additional support is provided by Kogan (18).

These studies, then, support the hypothesis that the more motivated P is to solve his problem, the more likely he is to continue. It is to be hoped that future studies will specify more precisely the nature of this association.

P's Personality. Until now we have considered P only with reference to his problems as seen by himself and agency personnel. However, a large number of studies have tried to differentiate between continuers and discontinuers with reference to more general personality characteristics. These will be discussed under the following headings: P's degree of disturbance, his anxiety, his ability for self-appraisal, his perseverance, and his capacity to communicate.

Findings pertaining to P's *degree of disturbance* are unclear in their implications. Fanshel (6), studying the intake of a family agency, concluded that "mental health" was not related to likelihood of continuance. Taulbee (35) has reported that the continuers in his sample of adult outpatients scored higher on the MMPI symptom scales than

did the discontinuers; but Sullivan, Miller, and Smelser (34) obtained no such differences in an essentially similar population. Lorr *et al.* (21) found that continuers less frequently had a history of antisocial acts. Such findings lead one to suspect that "disturbance" is not a useful indicator of continuance.

The evidence is much more consistent with regard to P's *anxiety*. Five different studies (7, 8, 21, 34, 35), all conducted at adult outpatient clinics, have reported that persons with high anxiety were more likely to stay in treatment than those with low anxiety. No contradictory evidence is at hand, and this finding is consonant with existing beliefs.

With respect to P's *ability for self-appraisal*, the various studies also are in agreement. Continuers have been found more insightful (6); less defensive in reporting their problems (8); more sensitive, more aware of their inadequacy, and with a higher potential for self-appraisal than the discontinuers (35).

Turning to data on *perseverance* in trying to solve problems, we find that continuers are described as less impulsive or nomadic (28), more dependable, controlled, and persistent in the tasks they undertake (20), and more persistent in the psychological testing situation (35).

The largest number of studies pertain to P's *capacity to communicate*. Fanshel (6) has reported that the client's capacity to communicate with the worker was associated with continuance of marital counseling cases, although no such association was found for other kinds of cases. In studies at clinics, Lorr *et al.* (21) reported that continuers were more willing to explore personal problems. Smigelsky (31) stated that they were better able to express their anxieties. Taulbee (35) found that they showed greater affectivity, dependence, and the need to be accepted, while discontinuers were more withdrawing. Hiler (12) and Gibby, Stotsky, Hiler, and Miller (9) concluded that continuers were more verbal than dis-

continuers, as shown by their greater responsiveness on the Rorschach test. Auld and Eron (2) have tried to explain such disparities in Rorschach responses in terms of intelligence differences, but Gibby *et al.* (9) found that I.Q. differences alone did not account for such results.

Socioeconomic Background. Following the lead of Hollingshead and Redlich (cf. 13), a number of studies have related socioeconomic status to the use of psychiatric services. The consensus of such studies is that professional help is more easily available to middle-class than to lower-class individuals, and that the former are more suited to it. Thus, Auld and Myers (3) have pointed out that differences in income are not alone accountable; middle-class patients are more "psychologically minded," and lower-class patients tend to obtain less psychological reward and more punishment from their use of psychiatric facilities.

In a comparative study of case loads at a psychiatric clinic and a family agency, Coleman and collaborators (5) have reported on continuance in treatment as related to differences in social class. Members of the two lowest social classes were less likely to go beyond the intake phase than members of higher classes. Also in a family agency, Fanshel (6) found a positive association between continuance and socioeconomic status; while continuance was not associated with age, sex, or race.

At adult clinics offering psychotherapy, various studies have supported the hypothesis that continuance is related to socioeconomic factors. At least five such studies have found a higher proportion of continuers among middle- than among lower-class patients (7, 9, 15, 28, 40).

In child guidance agencies, continuance and socioeconomic factors have been found less clearly related. Although two studies have supported the above findings, two other studies with larger samples failed to find any clear connection. In a study of 291 cases, Apte *et al.* (1) found that lower-class families had a larger proportion of

"short-term" contacts than did the middle- and upper-class cases, indicating more discontinuance among the former. Lake (19) also found that the social class of continuers tended to be higher than that of the discontinuers. In both these studies the difference was only barely significant at the 5 percent level. However, neither Maas (22) nor Tuckman and Lavell (37) have found continuance rates correlated with socioeconomic status. Maas's sample was that of 297 cases in New York clinics, while Tuckman and Lavell examined the records of 780 cases in Philadelphia. These findings are difficult to interpret. It is possible that lower-class patients who come to child guidance centers differ systematically from those who visit adult treatment agencies, but further evidence is necessary.

Regarding the lower-class adult patients, Sullivan *et al.* have commented that "... those persons who are least equipped to meet life challenges are the ones who stand to gain least from psychotherapy" (34, p. 7). Would this observation be less true of social casework or of treatment at children's clinics? Perhaps intellectual and motivational resources related to social status are more necessary to adult psychotherapy than to casework or to child treatment. Other aspects of socioeconomic differences will be discussed in the section on H's characteristics.

P'S CURRENT ENVIRONMENT

Turning now to specific factors which act upon P in his current environment, there is little *systematic* evidence at hand. Many more studies have focused on the personal than on the environmental attributes of persons in treatment.

Relationship to Significant Others. It would appear that a person's continuance in treatment is influenced, at least in part, by the actions and attitudes of those around him. Relatives, friends, and acquaintances may encourage or discourage a person from seeking help with his problems. Often

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"... the burden of trying to involve resistant relatives ... [appears] to contribute to client withdrawal" (29, p. 230).

The only systematic data pertaining to this topic known to the author are those gathered at a child guidance clinic in two successive studies (33, 19). The first study reported a greater probability of continuance when father as well as mother was seen during the application interviews; but the second study found little support for this conclusion. On the other hand, the latter study did obtain one highly relevant result: continuing families showed a much greater proportion of "positive agreement between the parents" than those who discontinued. The nature of P's employment, or lack thereof, is another condition which may affect his relationship with significant others. In one psychiatric clinic,⁵ housewives and patients with managerial or professional jobs were found more likely to continue than patients whose employment was more restrictive (7).

Relationship to Referral Source. Although a number of studies have reported differences among clients as related to the kind of referral sources which guided them to the agency, little information is available regarding persons' attitudes toward such sources. Two studies (19, 33) have suggested that continuers showed more positive attitudes to their referral sources than did discontinuers, but neither found strong support for such a statement.

There seems to be little systematic knowledge about the connection between P's environment and his continuance in treatment. This is worth noting. It would be relatively simple during initial interviews to obtain data regarding P's relationship to significant others, his attitude to referral sources, and about other environmental factors. If such data were available, one could answer a number of questions about P's continuance as it relates to his attitude toward agency and referral source, and to the support or disapproval he receives from other persons in his current environment.

H'S PERSONAL ATTRIBUTES

Training and Competence. In studies of therapists' responses to hypothetical patient statements, few differences have yet been reported among H's with different kinds of professional orientation. Thus it is interesting to note that existing studies of dropout rates have found similar lacks of differences. Two studies by Hiler and Sullivan *et al.* in adult clinics could find no difference among social workers, psychiatrists, and psychologists as to whether their patients discontinued their contacts. Nor was therapist's rated competence or length of professional experience found significantly related to continuance.

Hiler did suggest that the more "competent" therapists tended to keep in treatment a greater proportion of the "productive" patients, while the less competent therapists were better able to keep in treatment the less productive patients.⁵

Ability To Relate and Communicate. According to Shyne's review article, both caseworkers and clients have reported that the former sometimes are unable "... to meet the client on his own ground, as it were, allowing him to develop his problems as he sees them" (29, p. 230). Such an inability would impair the communication between H and P, and it would bear considerable study, but few research data are available. Hiler's study touches on this issue, but sheds only a little light. First, the therapist's "passivity," as rated by three colleagues, was *not* related to patients' continuance. Second, the therapist's "warmth" (rated similarly) was *positively* related to patients' length of stay, particularly for the "unproductive" patients.

Socioeconomic Background. Hollingshead and Redlich report that 95 percent of the psychiatrists in their study were "Class I" in their socioeconomic rating. Although most of them had "moved upward one or

⁵ Competence was judged by three colleagues, while productiveness referred to the number of the patient's responses on the Rorschach test.

more classes from the position occupied by their fathers," it is unlikely that many had an origin in Class III or below. Elsewhere these authors state that "the therapists and the class V patients are worlds apart socially" (13, p. 344).

There is no reason to suppose that psychiatrists are the only professional helpers who are separated from their clients by a sociocultural gap. Social workers are similarly hindered in their performance, although perhaps to a lesser extent. To quote Shyne, "... differences between client and worker in social class may be a factor in their difficulty in finding a common ground" (29, p. 231). At the present time, though, one can find no published reports which link H's socioeconomic characteristics to P's behavior in treatment, not to speak of his continuance.

Only three studies have been cited here and none are directly concerned with the performance of social work. The study of the effects of differential training and competence on worker performance would appear a fruitful area for research. The variable of client continuance holds promise to be one criterion of such performance. Its measurement avoids the difficult problems confronting the application of more refined yardsticks.

H'S CURRENT ENVIRONMENT

Although P's environment appears to contain the more significant determinants for P's behavior, H's current surroundings also can influence the P-H relationship in many ways. The difficulty facing this reviewer is the lack of research into the matter. Some of these influences might be considered "obvious" by the practitioner, yet their implications may go to the core of the P-H relationship. A few of the factors that affect H in his agency environment are discussed below.

Agency Policies and Relationships. Regardless of his professional training, H's connection with the agency both facilitates

and hinders his work. The organization provides a channel through which clients may reach him; it gives him an office and undisturbed opportunity to serve the client; it offers him various kinds of professional and administrative assistance. On the other hand, organization policies usually specify the amount of time H may spend with his clients (both the length and the number of interviews), the kinds of information he must seek from them, and the nature of help he may give. These are examples; one can imagine many other organizational benefits and liabilities. In any event, one must not ignore questions such as that raised by Gundlach and Geller (10): To what extent does P's continuance or discontinuance depend on P, and how much does it depend on H and the agency?

Aside from the agency's direct determination of H's behavior, there are also various subtle and indirect determinants. In industry, it has long been recognized that morale influences worker productivity, although the latest industrial studies shed doubt on the exact nature of this influence. Research on the interpersonal relationships and morale among "helpers" has been less common, but findings from studies of mental hospital wards (32) would caution us not to neglect such factors. Any broad attack on the determinants of H's behavior toward P should include an assessment of interpersonal relationships within the agency. Among the questions one would ask might be the following: To what extent is the interpersonal climate among agency staff conveyed to P? And how is P's impression of staff relationships related to his use of the agency's facilities?

Relationship to Referral Source. Another determinant of H's behavior toward P is his relationship to the organization or the individual who referred P. In certain instances, as when P is referred by a court or other organization with compulsory jurisdiction, H's behavior (and P's perception of H) will be governed accordingly. As another example, H is likely to treat P dif-

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ferently when he is referred by one of H's colleagues than when P comes through hearsay from some acquaintance.

Agencies have reported the nature of referral sources, and have even related this variable to the ultimate disposition of the case. The variable has not yet been studied extensively with reference to the P-H relationship. According to the present outline, then, the nature of the association between H's relationship to the referral source and P's likelihood of continuance constitutes a gap in our knowledge.

THE P-H RELATIONSHIP

The best predictor of P's continuance in treatment should be found in the actual transactions of the interviews themselves. One may note that social work researchers have so far been the only ones who have used case records to examine this aspect of the P-H relationship. The reason for this is hard to know. Perhaps social work researchers have more of a tradition of using case records as data, or perhaps other researchers have focused more on attributes of individuals than on attributes of relationships.

P-H Attitudes. In order to profit from the relationship, it seems that P must be able to share H's goals for the treatment. It is necessary that P have a positive attitude toward H (and vice versa) and a realistic conception of H's role. One would hypothesize, then, that the greater the potential for co-operation between P and H, the more likely it is that P will continue his interviews.

Blenkner (4) has presented data which would support this hypothesis. Two of the four factors which she found significantly related to continuance fall under this heading. First, clients who saw the worker in a "counseling role" were more likely to return for further interviews than those who saw the worker as principally offering "concrete service." Second, clients who "appeared to move forward" during the

first interview in accepting the worker in a counseling role were more likely to continue than those who did not.

In his subsequent study at the same agency, Kogan (18) corroborated Blenkner's finding. He reported that the clients with unplanned closing were less likely to have seen their problems "emerging" during the first interview. Furthermore, he noted that these persons also showed less liking for the worker than did the planned closers.

In Lake's study (19), a large difference was found between the continuing and the discontinuing groups of families. In judging the degree to which parents agreed with the worker's perception of the *core* problem, it was found that 82 percent of the continuers and only 32 percent of the discontinuers could be said to agree with the worker's definition of the problem and the services required.

These findings cast only a little light on the intricate nature of the P-H relationship. Yet they are in general agreement with the hypothesis outlined at the beginning of this section.

Additional information can be gleaned from studies by Thomas, Polansky, and Kounin (36) and by Worby (42), who investigated student subjects' perceptions of a "potentially helpful person." Both studies found that "helpers" are perceived as individuals who will consider the client's problems important, will show great effort to understand him, and will be committed to help him. Further, it was concluded that the more the helper is perceived as motivated to assist the client, the more likely the client is to commit himself to continue the relationship and to allow himself to be influenced by the helper.

Ease of P-H Communication. If we assume that the relationship between P and H is a two-way street, then the communication capacity of *one* member of the pair is insufficient to indicate the smoothness of *mutual* communication. One may look, therefore, for indications of the productivity of the communicative efforts.

Blenkner (4) and Kogan (18) reported some findings which seem relevant to this topic. Blenkner found that continuance was related to the favorableness of the client's response, during the first interview, to the worker's suggestions for solving the core problem. Clients who responded to such suggestions in a noncommittal or rejecting way were unlikely to continue the relationship. This finding is related to one of Kogan's—that the unplanned closers were more resistant to workers' exploration of their problems. Werble (39) obtained data consistent with these studies, namely, that continuers showed greater positive affect and behavior toward the social worker than did the discontinuers.

Such findings as these are only the beginning of efforts to obtain a more adequate picture of the initial interview. The compatibility between P and H at that stage should be indicative of later developments in their relationship.

P-H Social Distance. Social distance may be defined as the difference between individuals on certain attributes, *e.g.*, socioeconomic background or cultural values. It would appear that the greater the social distance between people, the more difficult it is for them to communicate with each other. Thus one would hypothesize that the probability of P's continuance is negatively related to his social distance from H. No studies thus far have investigated this hypothesis.

Time and Spatial Distance. Finally, it is likely that the relationship between P and H is affected by variables involving two kinds of physical distance: length of waiting period and geographical distance between P's place of residence or work from H's office. So far, there exists little evidence linking either of these variables to continuance.

One study has examined the length of waiting period after the application interview at a children's clinic in relation to subsequent continuance (19). No clear evidence was found that P's who were kept

waiting a long time (over three months) were more likely to discontinue than those who were kept waiting a shorter time. Similarly, in a study of continuance and termination at certain children's clinics in Philadelphia (38), P's distance from the clinic was not found related to continuance.

In this reviewer's opinion, new studies of length of waiting periods and geographical distance, employing adequate controls for related variables, will shed further light on the phenomenon of continuance. Such studies require easily obtainable objective data and may make a significant contribution to our knowledge.

FURTHER OBSERVATIONS

It is imperative to call attention to some limitations about generalizations from the studies which have been reviewed. The aim has been to arrive at a total picture of our knowledge about continuance, but differences among the studies affect the clarity of the view. Definitions of continuance have varied to some extent (as noted in footnote 2), and studies have differed also with respect to agency setting, nature of P's problem, and in the precision of research design or report of findings.

With regard to the settings in which the studies were conducted, there are undoubtedly wide differences among the goals and methods of family agencies, marriage counseling centers, children's clinics, and adult psychiatric clinics. It was decided to present findings from all four kinds of settings, since it seemed desirable to stress the similarity in the determinants of client continuance. This decision appears justified in view of the small number of available continuance studies. On the other hand, the disparities among the settings must also lead to variations in the findings. The differences among the studies reviewed also stem from the fact that different kinds of agencies serve clients with different problems—as well as having helpers with different backgrounds.

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As for methodological considerations, many of the studies cited suffer from shortcomings. At times one is unclear about the investigator's operational definitions and the data on which his assertions are based. Often the reliabilities among judges' ratings are not reported, or the statistical significance of findings is questionable. Furthermore, investigators rarely report the representativeness of their samples in relation to the population studied. Finally, with few exceptions, the studies utilize data that had been collected for purposes other than those of the particular research, often entailing difficulties in drawing conclusions.

Despite these limitations, it seems that some progress has been made in recent years in locating factors that are associated with continuance in treatment. Most of the references have been to publications within the last five years. One can notice an acceleration in the number of published studies.

Noting the multiplicity of factors that may be related to the phenomena of continuance and discontinuance, one is also impressed with the need for integrating future research according to gradually improving conceptual frameworks. The point may soon be reached where the mere accumulation of further data becomes meaningless unless such data are used either to verify previous findings or to fill gaps in already existing knowledge.

SUMMARY

This paper has been an attempt to integrate diverse findings concerning continuance in treatment. It was suggested that, in casework and other helping relationships, continuance is a function of numerous variables that affect the relationship between the person P and the helper H: variables composing P's personal attributes, P's current environment, H's personal attributes, H's current environment, and those pertaining more directly to the current re-

lationship between P and H. Despite the disparity of the sources of data, the general findings from various studies do not appear overly inconsistent. Thus, until further evidence is reported, the following tentative conclusions are justified:

Regarding P's personal attributes, continuers generally have greater discomfort, are more prone to see themselves responsible for their problems, and show higher motivation in trying to solve these and other kinds of problems. Moreover, continuers show greater ability to respond to the helping person and a greater willingness to explore their problems. Finally, in the treatment of adults, middle-class persons are more likely to continue than are lower-class persons, but this finding does not clearly apply to families at children's clinics.

Regarding P's current environment, the evidence is less explicit. There are some indications that continuers have a more positive relationship with significant persons in their environment than do discontinuers, and that perhaps their attitude to the referral source is more positive.

It was noted that there is little knowledge about H himself as an influence on P's continuance, particularly when placed alongside the knowledge about P's characteristics. There is some indication that H's professional training per se is unrelated to P's continuance, but that his warmth and social distance from P may be important. It seems obvious that further research is needed regarding H's personal and environmental characteristics.

Regarding the relationship between person and helper, studies have suggested that continuers are more able to co-operate and to identify with the helper, while discontinuers are more likely to be resistive. Further research may shed light on such findings, as well as on the influence of social and physical distance between person and helper.

This review has attempted to offer an over-all picture of current knowledge re-

garding continuance in casework and other helping relationships. By viewing continuance in terms of the total situation that confronts person and helper, a number of gaps in this knowledge have been apparent. In noting these, a number of questions and hypotheses have been proposed for further research.

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BY EDWIN J. THOMAS, DONNA L. McLEOD,
AND LYDIA F. HYLTON

The Experimental Interview: A Technique for Studying Casework Performance

THE ACTING OUT of roles, or "role-playing", has been used as a training device in personality assessment, in education and psychotherapy, and as a technique in survey research.¹ The use of role-playing for controlled, quantitative measurement is a recent development, however, and is still being explored and developed. This paper describes an adaptation of role-playing for the purpose of studying and measuring the performance of caseworkers in the casework interview.

The technique is termed the experimental interview and was one of the approaches to measuring change devised in connection with a two-year study of the effectiveness of in-service training and reduced workloads in the Aid to Dependent Children program of Michigan.² Each worker who participated in the experiments conducted a casework interview with an actress who took the part of an ADC recipient. The worker was told that he was participating in a role play with an actress taking the part of a client and was given the conception that he was interacting freely with the "recipient." The worker did not know, however, that all responses given by the actress came from a memorized script and were produced in accordance with pre-

scribed rules. By means of the rules and script, control and predictability of the actress' behavior were achieved. The set of facts about herself that the actress had available, coupled with a short case history made known to the workers just prior to entering the interview, were designed to create a single definable character. The result was a "client" who was living, responsive, and tractable, and who presented a relatively nonvarying stimulus situation.

Interviews were conducted identically for each worker participating in the research and were recorded on tape. Nonverbal behavior was recorded by a trained observer. From these records many aspects of the worker's performance were analyzed, and the performance of workers in different experimental conditions of the study compared. The performance of the workers was thus measured with greater precision and under conditions of greater control than would have been obtained by observ-

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¹ See Rosemary Lippitt and Anne Hubbell, "Role Playing for Personnel and Guidance Workers: Review of the Literature with Suggestions for Application," *Group Psychotherapy*, Vol. 9, No. 2 (August 1956), pp. 89-114; Howard Stanton, Kurt Back, and Eugene Litwak, "Role-Playing in Survey Research," *American Journal of Sociology*, Vol. 62, No. 2 (September 1956), pp. 172-176; John H. Mann, "Experimental Evaluations of Role Playing," *Psychological Bulletin*, Vol. 53, No. 3 (May 1956), pp. 227-234.

² Edwin J. Thomas and Donna L. McLeod, with the collaboration of Pauline Bushey and Lydia F. Hylton, *In-Service Training and Reduced Workloads—Experiments in a State Department of Welfare* (New York: Russell Sage Foundation, 1960).

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ing actual interviews with real recipients, or in examining role-playing behavior where the behavior of neither participant was controlled.

This article discusses specifically the content, procedure, and rules of the interview, problems of achieving credibility and control of the "client," the reactions of the workers, some types of analysis to which this technique might lend itself, and the reliability and validity of the instrument.

CONTENT, PROCEDURE, AND RULES

The experimental interview was used with 20 ADC workers after the first experiment and with 34 different ADC workers before and after the second. The same actress portrayed the recipient in both studies. The minor revisions of the script and rules made in the second study do not make the two studies incomparable for present purposes, for the rationale and procedure of the interview for both years were identical.

The interview was divided into six episodes, each involving the same recipient, but hypothetically occurring at different times in this recipient's history with the agency. The use of different episodes allowed coverage of a much wider variety of material than would ordinarily be included in a single interview. Four of the episodes were terminated after the worker's initial reaction to the problem presented by the "recipient." In the other two episodes interaction between the worker and the "recipient" was allowed to continue up to five minutes in one and to seven minutes in the other. The entire interview lasted from fifteen to twenty minutes. Illustrative of the content covered in the interviews are the episodes from the first experiment.

Episode 1. In this episode Mrs. Lang had received a report from the school stating that her son, Harold, was not doing well and had been truanting. The aim of the episode was to determine how adequately the worker obtained relevant facts from the recipient upon first contact when

he knew little more than selected face-sheet data. (Maximum of five minutes' free interaction allowed.)

Episode 2. Mrs. Lang's initial statement concerned her daughter, Barbara, who had been having nightmares that a bear was chasing her and who also showed fear of their dog. The aim was to test the worker's reaction to a complex child-care problem that may or may not have been serious. (Termination after worker's response.)

Episode 3. Mrs. Lang said that she had been making dresses for the girls with cloth that she had brought, but also that Harold did not like this and that he wanted the money used to buy the cloth. The purpose was to test whether the worker reinforced the strength of the client or explored the implied negative aspect. (Termination after worker's response.)

Episode 4. Mrs. Lang angrily expressed her feelings toward her husband, saying that he drank all the time and that he did not stay at home. She further expressed great hostility toward her husband, also blaming her son Harold. The objective was to test the worker's reaction to what might be indications of two defense mechanisms: displacement and projection. (Termination after worker's response.)

Episode 5. Mrs. Lang was depressed, saying that she had no money and could not do the things that she wanted to do. The intent was to test the worker's reaction to an expression of frustration and depression, which provided a generally suitable opportunity for the worker to support and reassure the recipient. (Termination after worker's response.)

Episode 6. Mrs. Lang indicated that she wanted to go to work, that she was tired of staying home all the time, and she asked the worker if she thought she might get a job. One of the objectives of this episode was to test the extent to which relevant facts relating to the employment situation were explored, and the way the worker handled the client's seemingly strong desire to seek

employment. (Maximum of seven minutes' free interaction allowed.)

Prior to the interviews a general orientation to the role play was given to the workers as a group in an attempt to create a relaxed atmosphere. Each worker was then approached individually and instructed to read a brief "case summary" as he might in preparation for a first interview with a client.

When the worker was ushered into the interviewing room and introduced to the actress, the latter was already seated in readiness for her role. It was explained that she would be playing the role of the client described in the case, and that the worker was to play himself in the role of worker as though it were a genuine interview. The moderator then read the introduction to the first episode, which called for the worker to leave the room and re-enter as though he were appearing for the first time to interview the recipient.

When the worker entered, the moderator sat behind the worker's chair and began timing and tape recording. In addition, the observer entered observations of the worker on a schedule, began each episode, and terminated the timed episodes when the worker did not stop voluntarily before the end of the allotted time.

The actress had problems, feelings, and a definite store of "facts" about her situation that she would reveal in a standardized manner in reply to certain responses from the worker. The rules of the script called upon the actress to give information in response to exploratory questions and to attempted reassurance. She was not to reply to direct advice or to suggestion, clarification, or explanation, unless followed by a question. She was to respond without commitment to suggested action stated in question form (e.g., "Will you go to Family Service?"). The actress was to follow these general rules without any attempt to judge the quality or appropriateness of a specific worker's response. The situations were so constructed as to require considerable ex-

ploration of the client's situation, problems, and feelings before appropriate suggestions or advice could be given. While giving information was sometimes appropriate, the majority of the worker's time should have been spent in seeking information. For these reasons the rules tended to reward workers with new information when they posed exploratory queries and gave reassurance, but not when they made more directive responses.

The information available to the actress was crucial to understanding and helping the client. Statements available were ordered into topical areas and were given by the actress in a specified sequence, progressing from those of lesser to those of greater depth within each area. When questioned in an area for which she had no information or in which available information was used up, the actress was to respond simply with "I don't know." She was allowed, however, to make up, in keeping with her situation or character, simple factual responses to questions for which an "I don't know" would have been absurd or would have suggested an emotional disturbance not intended in the characterization. Such a question would be, "How many rooms do you have?" Responses, of course, were the same each time the question was asked, and after several rehearsals there were few questions of this type that demanded new answers. In the second study three characteristic "defensive" responses were used by the actress throughout the interview following specified responses from the worker.

During the interview the actress gave most of her responses from memory, although she held her script in her lap under the table, and, when necessary, referred to it as unobtrusively as possible by glancing down as if pondering her response.

At the conclusion of the last episode the moderator talked informally with the worker for a few minutes and when asked "How did I do?" he gave legitimate reassurance on nontechnical aspects of the performance. The worker was requested not

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to discuss the experimental interview with the others in the bureau until all interviews had been completed, and was given a post-reaction questionnaire to complete. As soon as the worker had left, moderator and actress rated him along several dimensions.

ACHIEVING CREDIBILITY AND CONTROL OF THE "CLIENT"

The major technical problem of the interview was to develop the role of the actress so as to achieve maximum control while also creating a lifelike individual who could easily engage a worker in interaction.

One mark of a credible "client" is that his repertoire of responses is not too small. The actress' repertoire was of course small as compared with the seemingly limitless supply of most people and, in the first study, caused the interaction to lag at times. This problem was worked out in the pilot stages of the second study by allowing the actress to respond simply and consistently to all factual questions where "I don't know" would seem incongruous, and by providing the actress with more responses related to feelings and family relationships, placing these in a logical sequence so that a worker was rewarded for continuing to explore in areas in which responses were forthcoming.

A credible "client" is also one who responds quickly and spontaneously. The talents of the actress are clearly crucial, for her task is a demanding one. How many bits of information and the complexity of the rules for responding depend to some extent on the capabilities of the actress. A good actress must have skill in creating a believable character; a high degree of intelligence and rapid reaction time are required for classifying each remark of the worker as it is made, selecting the correct response according to the rules, and delivering this response in the appropriate manner, without destroying the impression of spontaneity.

The demand for control and the difficulty of the actress' task determined to some

degree the character of the recipient that was developed. It would have been more difficult, for example, to develop a client who imposed herself, responded very quickly and brightly, talked garrulously, and interrupted the worker. Despite the constrictions on the actress' behavior most workers reported that the interview seemed lifelike. All but three indicated on the post-questionnaire that the actress seemed realistic and reported that her problems were believable. A few even said that they forgot it was "role-playing."

Even though the task of the actress was complex, her responses were highly predictable. In the two long episodes a maximum of twelve minutes of free interaction was allowed between the actress and the worker. In the first experiment 81 percent of the actress' responses were predictable from the script; the figure for the second year was 91 percent. A predictable response of the actress was one that could be anticipated exactly from knowledge of the rules and script before the response occurred on the playback of the tape. In the four episodes that did not allow free interplay between the actress and the worker, but closed with the worker's response to the actress' presentation of her problem, the comments of the actress were of course totally predictable. Furthermore, the actress was able to maintain a consistent emotional tone and bearing throughout, and in no instance was she observed to break out of her role. However, the stimulus situation was only *potentially* the same for each worker. The actual amount and kind of information the worker received depended on his own responses, and hence actual situations may have varied considerably within the range set by the script.

REACTIONS OF THE WORKERS

Besides the technical problems of control, the researchers faced the task of enlisting the co-operation of the workers without arousing anxieties. Activities that are

normally witnessed only by the worker and his client were open to public view in the experimental interview. Thus the workers could easily have experienced uncertainty and apprehension. In order to minimize such undesirable effects, the researchers stressed their interest in learning more about technical aspects of the interview process and said nothing about evaluating the worker's performance. Workers were assured of anonymity and told that only data for aggregates rather than individuals would be reported.

Of the 56 workers who participated in the research, six were noticeably upset by the role play and required some special reassurance by the moderator, and two of these were excused from participation. Reactions of the other 50 ranged from the appearance of being ill at ease to obvious enjoyment of the experience. In reporting their own reactions, less than a third of the workers said that they experienced considerable anxiety during the interview; the remainder of the workers reported little or no anxiety. Apparently the strangeness of the situation and uncertainty about what to expect accounted partially for the workers' apprehensions, for in the "after" interview fewer workers than in the "before" interview stated that they experienced anxiety. Responses to questions about the effect of the tape recorder suggested that recording generated uneasiness for only a few workers.

Most workers appeared to enter into the role play quite well, for there were but a few instances when the worker turned aside to make comments to the observer or otherwise departed from his role as social worker. Most of the workers remained focused on the situation and were absorbed in the task. The worker's motivation in the interview, however, was judged to be less the second time it was conducted.

From the experience of these studies we conclude that it is feasible to use the experimental interview to study the performance of caseworkers, but with the caution that

the researchers be particularly sensitive to the feelings of the participants so as to minimize test anxiety.

USES OF THE EXPERIMENTAL INTERVIEW

The experimental interview is one of many experimental analogues having potential usefulness for investigating the behavior of caseworkers and similar helping persons.³ It is clearly best suited to investigation of the worker's behavior in response to a controlled and predictable "client." Other analogues and nonexperimental methods must be used for studying the effects of a worker's behavior on clients.

Hypothetically, any aspect of the worker's behavior in the experimental interview may be studied. The methods of influence used by the workers studied in the Michigan ADC experiments are briefly described as an example. Whether or not the worker employed directive, imposing methods of influence was of particular interest, although nondirective approaches were also examined. The following categories indicate how responses were coded from the taped records: *the imposition of the worker's ideas*, as shown, for example, by instances of giving advice, opinion, or evaluation with respect to the goal that the client might pursue or other aspects of the client's life situation; *exploration*, as evident in the worker's unbiased questions intended merely to gain information; *differentiation*, indicated by neutral statements that served to define some aspect of the client's situation.

Other measures obtained from an analysis of the taped recordings included the appropriateness of the worker's initial response to the presented problem, the number of appropriate supportive responses given by the worker, the average number of words

³ For a discussion of eight experimental analogues see Edwin J. Thomas, "Experimental Techniques for Studying the Casework Interview," in *Proceedings of the First Annual Michigan Tri-University Student Social Work Conference*, McGregor Memorial Conference Center, Wayne State University, 1960. (Mimeographed.)

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spoken per response, the amount of information obtained and how it was used, and the length of time taken by the worker in the interview. Also, over-all ratings were made by the observer during the interview on the worker's discomfort, confidence, investment in the interview, and likability.

As illustrated above, the experimental interview is suitable for measuring changes in the worker's performance with clients associated with the introduction of given experimental variables. The technique also permits direct comparison of workers on specific aspects of interviewing technique under conditions where no experimental variables are being evaluated. Thus the recorded tape of workers' performance in experimental interviews could be compared with their written accounts of the interviews to study systematically the strengths and weaknesses of case records for purposes of research.

In addition to its uses in research, the experimental interview, with some adaptations, lends itself to training caseworkers, with the tapes used to substitute for or to complement case records in the teaching.⁴

EVIDENCE CONCERNING RELIABILITY AND VALIDITY

One of the first questions that must be asked in evaluating this instrument is how reliable it is.⁵ Because the workers in the second experiment participated in the same interview on two separate occasions, it was possible to examine test retest reliability.

Such formal and temporal features of interaction as the amount of time used in the interview, the number of words spoken, and the number of words per interchange were relatively stable. Workers also tended

to perform consistently with regard to amount of exploration, imposition of goals, and total influence attempts. Evidenced discomfort and apparent confidence were also relatively stable, at least as judged by the observer.

Workers performed less consistently with regard to differentiation, amount of information obtained, and investment in the interview. The workers as a group also spent less time, spoke fewer words, and invested less in the second interview as compared with the first. These differences may be attributable to the effects of participating in the experimental interview a second time.

The validity of the experimental interview was difficult to evaluate because there was no direct way to determine the extent to which the caseworker's performance in playing his own role in the experimental situation was representative of his day-to-day performance, at least for these variables measured. And past research provides only general support for the validity of this particular adaptation of role-playing.⁶ Positive correlations of measures of workers' performance in the interviews with independent measures of improvement in the situations of families seen by these workers constitute an indirect test of validity. Statistically significant relationships were found between measures of family improvement and the more benign methods of influence used by the interviewer, as well as the diagnostic acuity evinced by him in his post-interview diagnosis of the case portrayed by the actress. To generalize more confidently about the validity of the experimental interview, however, a sample of the behavior of workers with actual recipients would need

⁴ Prof. Patricia Rabinovitz of the University of Michigan School of Social Work is currently developing tapes of experimental interviews for purposes of teaching.

⁵ "Evidence Concerning Reliability and Validity: An Addendum" is available from the authors on request.

⁶ For details see Edgar F. Borgatta, "Analysis of Social Interaction: Actual, Role Playing, and Projective," *Journal of Abnormal and Social Psychology*, Vol. 51, No. 3 (November 1955), pp. 394-405; and Howard R. Stanton and Eugene Litwak, "Toward the Development of a Short Form Test of Interpersonal Competence," *American Sociological Review*, Vol. 20, No. 6 (December 1955), p. 670.

to be compared with the workers' test performance.

CONCLUSIONS

Two conclusions emerge from the preceding discussion. The first is that the experimental interview is a feasible technique for studying the performance of caseworkers in the casework interview. Thus it may be used to create a "client" with known characteristics who appears genuine and spontaneous in the casework interview, yet is a "client" who is predictable and does not vary from worker to worker. There are limits, however, on how complex the "client" can be made, depending upon the ingenuity of the investigators and the talent of the actress portraying the "client." Most workers can successfully take their own role as worker in the interview and can do so without experiencing undue anxiety. In general the evidence presented in this report suggests that the

experimental interview has sufficient reliability and validity to warrant its use in many types of inquiry in which the objective is to assess the interviewing behavior of caseworkers. When combined appropriately with other techniques for studying the behavior of clients, the experimental interview also has promise of yielding further knowledge about processes of change in the casework interview.

A second conclusion emerging from our experience with the experimental interview is that it is a reactive technique; *i.e.*, the experience of participating in the interview on one occasion affects the worker so that his performance upon retesting is in some respects different from that in the first test. This technique, therefore, should preferably be used in research designs requiring only one testing of workers; before-after testing should be used, if at all, for the measurement of variables known to be unaffected by the initial experience with the interview.

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BY LUTHER E. WOODWARD

Increasing Social Work Effectiveness in Meeting Mental Health Needs

The problem facing the nation for which the mental health professions must take basic responsibility encompasses the treatment of the mentally ill persons in our society, the detection of those becoming ill or who are so distressed that they are potentially ill, and effective participation in community activities that are thought to promote mental health or at least help develop a society conducive to healthy living.¹

SOCIAL WORK has a major and undelegatable responsibility to contribute all it can to the resolution of this threefold problem. Psychiatric social workers in large numbers work closely with psychiatrists, psychologists, nurses, and others in the treatment of the ill. With regard to detection of those becoming ill and community activities to promote mental health, the total social work profession is focally and extensively involved. The concern of this paper, after noting the size and nature of the problem, is to suggest some ways of increasing social work's effectiveness in dealing with it.

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THE ILL TO BE TREATED

A few nationwide statistics will serve to indicate the size of the problem of treating the mentally ill. Figures for 1958 show that of the 6,786 hospitals of all types in the United States, 518 are psychiatric.² In any year, the mental hospitals care for about 1,070,000 different persons; there are also upward of 60,000 patients in institutions for the mentally retarded.

Of the 1,558,691 beds in all hospitals, 45 percent are psychiatric. But on any day, 50 percent of the 1,322,938 patients who occupy these beds have mental illnesses. Yet of the 23,697,157 patients admitted to all hospitals in a year, only 2 percent are psychiatric admissions, whereas 95 percent are general. Only 17 percent of the personnel employed in all hospitals are in the psychiatric services, although they have half the patients at any time.

Substantial numbers of additional patients are treated in outpatient clinics and in the private offices of physicians—an estimated 379,000 patients in all categories in psychiatric clinics and 365,000–451,000 by private psychiatrists. Adding these figures to the number of patients in hospitals, we

¹ Opening paragraph of a recent draft of *Mental Health, U.S.A.*, scheduled for publication by Basic Books as a final report of a national health survey by the Joint Commission on Mental Illness and Health.

² Figures here and on the following page, unless otherwise noted, are from statistics of the American Hospital Association and the National Institutes of Health.

get an estimate of 1,814,000 mentally ill persons who are in treatment in a year, or over 1,700,000 when allowance is made for multiple counting. This includes no estimate of the numbers being treated by the approximately 110,000 physicians outside the practice of psychiatry; the thousands treated in general hospitals without special arrangements for psychiatric patients; and other thousands treated by the increasing numbers of clinical psychologists and social workers in private practice.

Prevalence studies in selected communities place the probable number several times higher,³ while psychiatric studies of groups in the population have yielded unexpectedly high figures.⁴ Supporting evidence of another kind comes from a nationwide survey made for the Joint Commission on Mental Illness and Health. Nineteen percent of a random sample of adult nonhospitalized population stated in interviews that they had at some time "felt

that they were going to have a nervous breakdown"; 15 percent had actually sought professional help for the mental health problems. The commission summarizes by stating that in spite of the crowding and frequent inadequacy of hospital and clinic services, these are in touch with and give service to only a small percentage of the population needing them. "Insofar as we can determine, at least . . . 10% of the population have some type of mental illness that is serious enough to warrant treatment if the sufferer wished it. This means 17,500,000 persons in the nation."⁵

Notwithstanding these figures, for the first time in our national history there has been a *decline* in the daily census in our large mental hospitals for the last two or three years. Mental hospitals have had about 52,000 fewer patients in 1959 than expected. This is due to the increased discharge rate which is believed to result from the "open" hospital policy, the use of tranquilizing drugs, dynamic psychotherapy, and other improved forms of hospital treatment.

The accelerating movement toward open mental hospitals provides social work with an opportunity to re-examine and possibly change or expand its role in the hospital team.⁶ Central concepts of the open hospital are:⁷ that the enormous disability associated with mental illness is to a large extent super-imposed—is preventable and

³ See P. Lemkau, C. Tietze, and M. Cooper, "Mental Hygiene Problems in an Urban District [Baltimore]," in *Mental Hygiene*, Vols. 25-27 (1941-43); W. F. Roth and F. R. Luten, "The Mental Health Program in Tennessee, I: Description of the Original Study Program; II: Statistical Report of a Psychiatric Survey in a Rural County," *American Journal of Psychiatry*, Vol. 99, No. 5 (March 1943), pp. 662-675; Ernest M. Gruenberg and Michael Shepard, "The Age of Neuroses," *Milbank Memorial Fund Quarterly*, Vol. 35, No. 3 (July 1957), pp. 258-265.

⁴ In the Yorkville section of New York City a study of 660 random persons between the ages of 20 and 59 showed 23.4 percent seriously impaired mentally, 21.8 percent moderately disturbed, 26.3 percent mildly disturbed, and only 18.5 percent to be well (reported by Dr. Thomas S. Langner of the Medical College of Cornell University at a meeting of the American Psychopathological Association held in New York City, February 1960). Studies by Dr. Leighton and co-workers in Nova Scotia (published in the *American Journal of Psychiatry* in 1956) and a small study in Salt Lake City also indicate unexpectedly high prevalence rates in the population. Statistics in New York State kept reliably over many years now indicate the expectation that one person in eight in the course of a lifetime will have a mental illness requiring a period of hospital care.

⁵ Gerald Gurin, Joseph Veroff, and Sheila Feld, *Americans View Their Mental Health: A Nationwide Interview Survey* (New York: Basic Books, 1960). The survey was conducted by the Survey Research Center of the University of Michigan.

⁶ The role of the psychiatric social worker in a working relationship with psychiatry and other hospital personnel is widely recognized and has been amply discussed. See Tessie D. Berkman, *Practice of Social Workers in Psychiatric Hospitals and Clinics* (New York: American Association of Psychiatric Social Workers, 1953); Ruth Knece, *Better Social Services for Mentally Ill Patients* (New York: American Association of Psychiatric Social Workers, 1955).

⁷ Robert C. Hunt, *Ingredients of a Rehabilitation Program in an Approach to the Prevention of Disability from Chronic Psychoses* (New York: Milbank Memorial Fund, 1958).

Meeting Mental Health Needs

treatable; and that hospitalization as such is an important cause of disability. Since mental disorders for which definitive treatment exists are very few in number,⁸ and since social work has built up over the years special knowledge and skill in social relationships, the potential contribution of case-work and group work to hospital patients may be very great—possibly even greater than psychotherapy, whether individual or group.⁹

FINDING THOSE WHO NEED TREATMENT

Over and above those having some mental or emotional illness, there are many others who are so distressed by inner tensions or social pressures as to be in danger of becoming ill. To be counted among the vulnerably distressed are fairly liberal estimates from various annual summary figures, such as the 385,000 couples who are divorced, the 183,000 illegitimate pregnancies, the 717,000 persons who are arrested for drunkenness and disorderly conduct, the 195,000 arrests for juvenile offenses, and the more than 1,000,000 crimes varying in severity from auto theft to murder. A debilitating degree of distress is almost sure to be found among the severely disabled—the blind, and the permanently and totally disabled persons on public assistance. A rather large proportion of older persons receiving care in homes for the aged and nursing homes have mental symptoms to some degree; children in many children's institutions and agencies are often

found to be more disturbed than those seen in psychiatric clinics.

Outside hospital walls, the social work profession, along with the other mental health professions, must find the vulnerable persons and get those who need treatment to treatment facilities. This is especially true for groups in greatest economic need, for the stubborn fact remains that the most distressed social class, with which social welfare is most involved, is least well served by community treatment resources.¹⁰ While growing numbers of projects for multiproblem families are being carried out,¹¹ social work's task in securing more psychiatric and casework treatment for the distressed is far from completed.

BASIC SOCIAL SERVICE FOR PREVENTION

Social work has a significant and undelegatable part to play through participation in community activities to promote mental health and prevent mental disorders. Except for the few mental diseases which have known organic causes, such as trauma, infection, poisoning, or malnutrition, main reliance in prevention has to be placed on social procedures and activities that will reduce tension, dependency, and frustration on the one hand, and on the other build ego strength and increase social adaptation and personal satisfaction. This social emphasis is likely to endure, inasmuch as more than two-thirds of the mentally and emotionally ill suffer illness from psychosocial causes. While the prevention of illness stemming from psychosocial causes cannot be nearly so definite as that of organically based illness, there are significant clues to the need for services which have long been considered basic in the social work profession.

Two services that have implications for

⁸ See Paul H. Hoch, "Etiology and Epidemiology of Schizophrenia," *American Journal of Public Health*, Vol. 47, No. 9 (September 1957), pp. 1071-1076; Ernest M. Gruenberg, "Application of Control Methods to Mental Illness," *American Journal of Public Health*, Vol. 47, No. 8 (August 1957), pp. 944-952.

⁹ Gisela Konopka, "The Role of a Social Group Worker in the Psychiatric Setting," *American Journal of Orthopsychiatry*, Vol. 22, No. 1 (January 1952), pp. 176-185; Hyman J. Weiner, "The Hospital, the Ward, and the Patient As Clients: Use of the Group Method," *Social Work*, Vol. 4, No. 4 (October 1959), p. 57; Luther E. Woodward, ed., *Psychiatric Social Workers and Mental Health* (New York: National Association of Social Workers, 1960).

¹⁰ August D. Hollingshead and Fredric C. Redlich, *Social Class and Mental Illness* (New York: John Wiley and Sons, 1958); Jules Coleman, "Mental Health Consultation to Agencies Protecting Family Life," in *The Elements of a Community Mental Health Program* (New York: Milbank Memorial Fund, 1956).

¹¹ See the SOCIAL WORK INDEX for 1959.

mental health have to do with childhood and old age—the two points at which our population is now bulging. Isolation, bereavement, and nutritional defects (not only from poor diet but also from lack of social stimulus) frequently have direct relation to mental disorders of the aged; prevention involves protection from social and intellectual atrophy. Approximately 16,000,000 persons in the United States are above the age of 65, and the number increases by 400,000 or more each year. Over 5,000,000 are over 75, which represents a 25 percent increase since 1950.

Population forecast indicates that there will be 70,000,000 children under 18 years of age in our country by 1965. Major responsibility for the maintenance of family life for children rests with social welfare. Special studies have indicated that there is no substitute for family life, and therefore it has become a social work goal for every child to have a family of his own.¹²

An increasing task will be that of service to persons coming out of mental hospitals sufficiently recovered to live in the community but still requiring special help. Schizophrenia and certain other illnesses cannot as yet be prevented or shortened in duration, but can be rendered less disabling. Ex-patient clubs, supervised residencies, sheltered workshops for vocational training and interim employment, and supportive casework with patients and families are measures within the special competence of social work. Through such efforts the discharged hospital patient may be helped to carry the responsibilities of home-making and child-rearing, financial contribution to the family, and participation in useful social organizations.

¹² Laurretta Bender, "There Is No Substitute for Family Life," *Child Study*, Vol. 23, No. 3 (Spring 1946), pp. 74-76, 96; J. Bowlby, *Maternal Care and Mental Health*, World Health Organization Monograph Series (Geneva, 1951); G. R. Hargreaves, "The Protection of Personality Against Lack of Necessary Relationships and the Presence of Damaging Relationships," in *The Elements of a Community Health Program* (New York: Milbank Memorial Fund, 1956).

The potentialities in all such services are significantly large. Yet it is clear that in many communities they are almost wholly lacking.¹³

SOCIAL TENSIONS

Since the social work profession developed as an instrumentality for dealing with social change and for providing related services that are needed to conserve and extend human values, it must, in line with this origin and tradition, be concerned about current social changes and their attendant tensions. One problem area with implications for social work in mental health is the impact of migration and geographic mobility on family life. Here we must think not only of Puerto Ricans, Mexicans, and the southern Negro (who migrates to the harvest fields and industrial centers of the North), but also of the middle class family on its way to the suburbs, as well as the "organization man" who is shifted periodically with his family from one part of the country to another. The role of the family and the security of children are sharply affected in all these instances, while on the aged—who formerly relied on the "extended family" for support and a feeling of belonging—migration, housing shortages, and community changes have imposed severe strains, reflected in the mental health statistics.

Attendant on this geographic mobility and the corresponding flux of ideas and philosophies of the last two decades have come insidious changes in the psychosocial climate, particularly in relation to parents and the rearing of children. With the loss of family and neighborhood, young parents have felt isolated and obliged to carry on entirely on their own. Turning to the experts for guidance, they found that these did not agree with each other, except to stress the importance of the early childhood years in family living and the operation of

¹³ Reginald Robinson, David DeMarch, and Mildred Wagle, *Community Resources in Mental Health*, to be published by Basic Books in September, 1960.

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powerful, unconscious forces which might, with understanding and skill, be enlisted on the side of health, but if not properly directed might well issue in illness and handicap. Compounding the difficulty have been the "parent-blaters" with a viewpoint warped by too much experience with too small and unrepresentative a sample of parents. The judge who deals only with the parents of the 3-odd percent of youth comprising the delinquent group becomes over-impressed with the apparent mistakes or irresponsibilities of this small group of parents and then generalizes that modern parents are fools or failures. Mental health clinicians, also, have often implied parental blame for the development of mental and emotional illnesses. Many parents have been frightened by the thought that their own ever-so-well-intentioned behavior could result in illness or delinquency of their children. Small wonder that many a mother has wished she had grown up in some simple tribal culture where all babies are brought up in the same way, and all mothers learn from their mothers and neighboring families! Of course, when they wake out of this fantasy, modern parents still find themselves in the throbbing American scene, trying their best, albeit with anxiety, to build into their children love, self-discipline, and a useful and satisfying set of values.

In the nationwide mental health survey cited above,¹⁴ a representative sample of persons from various types of community throughout the country were questioned regarding some of the satisfactions and dissatisfactions they derived from life, their tensions and concerns, resources and strength; the problems they face and the way they cope with them. Although the questions freely permitted people to name their sources of worry, few mentioned atomic war, civil rights strife, high taxes, or the political party in power. Instead, people say they worry mainly about their families, especially their children; about money,

their health, and their job—all intimate affairs of day-to-day living. In view of this close-to-home nature of stress, it is important in planning mental health programs to direct them toward services that will enable each person to cope with his personal problems and to stimulate the formation of public agencies that will render support and aid as he copes with them. In this perspective of the basic sources of anxiety and worry in the American population, the basic social services to families and individuals in distress over problems of everyday living become even more important than we have heretofore assumed.

Fortunately, social changes and their tensions force new questions, then adaptations. The high rate of rejection and early discharge from the armed forces for psychiatric reasons during World War II brought home to every community an awareness of the high incidence of emotional disturbance and personality disorders in the younger generation. Parents asked "Where have we made mistakes?" Educators and community leaders wondered where the social institutions had failed their youth. As a consequence, five times as many community psychiatric clinics have been established in the United States since the end of World War II as had existed prior to that time. A favorable by-product of all this concern has been the acceptance of mental and emotional illnesses as valid illnesses, fairly responsive to treatment. People could then do more than feel ashamed; they could take steps to be treated. The change in attitude has gone so far that in some quarters it is now fashionable to have a not-too-uncomfortable neurosis, and even more status-building if one can afford treatment at a well-known center or "elite" address.

Just as adaptation was needed to meet mental health needs after World War II, so new adaptations are now needed to meet the current genuine needs for service. What can be done to increase social work's effectiveness?

¹⁴ See Footnote 5, above.

SOME OVERUSED INSTRUMENTS

As with most of our society's institutions, the social work profession sometimes allows its tools to be so overused that they become virtual impediments. This has come to be true of recording and supervision. The reader will probably agree that whatever is constructive or effective in social casework happens in the face-to-face relation of worker and client. Whatever keeps clients from seeing social workers or keeps workers from interviewing and counseling with clients should be viewed with great suspicion. Yet the median number of interviews per 100 clock hours of social workers' time in outpatient clinics in New York State, for example, is 34. In some clinics, only one-sixth of the clock hours are used in interviewing patients, relatives, or other collateral persons. While interviewing cannot be the social worker's sole function, these figures are distressingly low. Excessive, repetitious, and poorly organized recording is responsible for a fair amount of this waste. Needed for the record are salient, significant facts regarding the client and his past and present relationships, growth or movement in understanding, and more effective resolution of problems. Limiting recording to really salient facts and significant movement would, in the opinion of some, reduce by perhaps 75 percent the volume of records and the time required to make them, with a corresponding reduction in the cost of transcription and increase in their actual use.

The social work profession has rightly prided itself on having developed unusual skill in the art of supervision, to which psychiatry and psychology repeatedly give praise by word and by their own adoption of the principles and procedures laboriously worked out through the years. However, in many clinics and agencies this extends far beyond the point of usefulness. Workers are kept in a needlessly dependent relationship long after they should be standing on their casework feet and exercising

sound judgment and making wise decisions on their own. In no other profession is the ratio of supervisory time to rank-and-file time so high, and in no other profession is it so much the general practice that supervisors only supervise and do no casework themselves. Imagine a chief surgeon performing no surgery! The profession might have grown faster, and much more casework and clinical work have been accomplished, if supervisors had become consultants primarily, with consultation provided largely on request. This would free substantial clock hours of both supervisor and regular worker for seeing more clients or patients.

Another perfectly good practice that has snowballed is the repetitious use of diagnostic examinations and referrals. Rightly we have been taught to engage in social diagnostic thinking as an essential step in giving service, and in making appropriate referrals to other agencies or professional persons. But in too many agencies these have become dead-end activities. The wastefulness of repeated examinations and referrals cannot be laid entirely at the door of the social worker; other members of the clinical team are just as guilty, and the wasteful practice occurs in psychiatric hospitals, outpatient clinics, child-care institutions and many other forms of service organization. The New York State Department of Mental Hygiene about two years ago instituted a detailed statistical reporting system for all outpatient clinics in the state. Sixty-eight percent of the patients whose service was terminated between April 1958 and March 1959 had received only diagnostic and/or referral service. The clinics themselves classify only 32 percent as receiving any treatment.

In a study of 1,000 applicants to six residential treatment centers,¹⁵ it was found that most children, by the time they are admitted to a residential treatment center, have had

¹⁵ Donald A. Bloch, M.D., and Marjorie L. Behrens, *A Study of Children Referred for Residential Treatment in New York State* (Albany, N.Y.: New York State Health Resources Board, 1959).

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six complete diagnostic work-ups by as many different agencies, over a five-year period. Such repetition of even the most excellent clinical procedures is a tremendous waste of human energy and of funds.

REALISTIC, GOAL-LIMITED SOCIAL TREATMENT

On the positive side, social workers can provide to more patients appropriate, realistic, goal-limited social treatment. In certain particulars, many workers in the mental health field seem to have learned too well from their psychoanalytic confrères. They try desperately, without philosophic or methodological adaptation, to hold to the illusion of patient "cure," and simultaneously cling to the notion that high professional status can be maintained only if one is a depth therapist.

Yet in New York State, for example, 29 percent of all patients and 43 percent of treated patients in the 232 outpatient clinics withdraw, most of them in the early period of their contact with the clinic, and 64 percent are seen only one to four times. In a good number of clinics that select only patients believed to be well motivated for fairly intensive treatment over a period of 6 months to 2 years, more than 50 percent of such patients do not get beyond the fifth interview.¹⁶

Social workers would make a greater contribution to the mental health of people who come to clinics and agencies if they concentrated on doing casework and counseling with them about their problems in social relationships. To be effective, treatment must be suited to patient *needs* and *limitations*. Usually, of course, these people have emotional problems and intrapsychic tensions which must be understood and dealt with. But they get more help, faster, if primary focus is maintained on present

problems and relationships and secondarily on related earlier and similar interpersonal situations in which unhealthy repetitive patterns have been more or less set. Most patients learn both emotionally and conceptually, and get useful insight while receiving help with some painful psychosocial crisis, without extensive exploration of unconscious forces. They can then manage with somewhat less distress and greater comfort, while keeping most of their defenses intact. The need is for a broad spectrum of services, including very brief service in connection with critical situations, intermittent services as new problems arise which increase the desire for help, and long, sustained treatment for those who *need* and *want* it and can handle the personal costs.

One child guidance clinic has sought to handle the waiting list problem by making a policy decision to provide all applicants with complete diagnostic studies and limit all therapy to three poststudy interviews. This sounds like a radical policy, and in some ways it is; but it was found that children as well as parents established rapport more quickly and made fuller use of the few treasured therapeutic hours. Moreover, 85 percent of the child patients and their parents were sufficiently satisfied with the service not to seek more, although it had been offered to all parents who might request it.¹⁷ This may well be considered—as it has in fact been called—a "push-in-the-right-direction" therapy. But is it not more respectful of the essential dignity and resourcefulness of people to approach them in this way than to assume at once that they are very sick and will have to be nursed along over an extended period of time?

Gruenberg and Bellin¹⁸ have pointed out that patients or clinics tend to conceptu-

¹⁶ Luther Woodward, Robert Patton, and Cynthia Pense, "The Value of Statistical Reporting in the Planning and Revision of Mental Health Programs." Paper presented at the annual conference of the American Orthopsychiatric Association, 1960.

¹⁷ Evelyn Alpern, M.D., "Short Clinical Services for Children in a Child Guidance Clinic," *American Journal of Orthopsychiatry*, Vol. 26, No. 2 (April 1956), pp. 314-329.

¹⁸ Ernest M. Gruenberg and S. Bellin, "The Impact of Mental Disease on Society," in *Social Psychiatry* (New York: Basic Books, 1957).

alize their problems in terms of their therapist's frame of reference. Also, the therapist generally tries to get the patient to acknowledge his illness and his need for treatment. To what extent does the process of self-perception as mentally ill make the patient sicker, and to what extent is this a necessary phase in recovery? It may also be asked: Does the conversion of social case-work to psychotherapy in clinics and family service agencies entail the risk of serious side effects which may counterbalance the beneficial effects of the agency's service?

The problem of adapting community clinics better to meet current needs has been well expressed as follows:

As a member of the clinic team, the psychiatric social worker should share responsibility for needed changes in the role of psychiatric outpatient clinics. The ratio, now and in the foreseeable future, of trained personnel to the number of people needing or even wanting help, the advances in chemotherapy, the accumulating studies regarding the effectiveness of traditional clinic treatment * and the selective factors in terms of population groups served, the rapidly mounting mental hospital release rate and the tendency of clinic personnel to hang on to the concept that curing is of greater value than helping in a crisis situation—all point to the need for reappraisal of the role of the clinic in a community mental health program. As social work's representative on the clinic team, the psychiatric social worker can probably contribute less to this reappraisal as a "proxy psychotherapist" than as a professional worker with special skills and knowledge of environmental factors combined with an understanding of the unconscious implications of overt behavior. The universal and virtually exclusive reliance on psychotherapy in clinic practice deserves careful

study as does the scanty use of home visits. More experimentation should be encouraged with goal-limited treatment programs to determine how the clinic can serve population groups that are now not generally served.¹⁹

EXTENDING SOCIAL WORK ROLE

Social workers can extend the social dimensions in mental health work by discreetly extending their own roles to include those of consultant and educator.²⁰ Even concepts of mental illness and mental health are changing, with accentuation of social factors. The ill or maladjusted person is seen as a product of social and societal forces as well as of organic pathology or intrapsychic conflicts. This broadening of concept and interest is reflected in the ten studies recently made by the Commission on Mental Illness and Health, which go far beyond an account of strictly psychiatric facilities and include the roles of all our basic institutions and their significant inter-relationships.

Nine states, among them populous New York and California, have broadened the social base for mental health work by including local government and total community through authorizing the establishment of community mental health boards, whose duties are to study the needs and facilities of the community and develop plans for expanded and improved services, with guarantees by the states to reimburse the communities substantially for the cost of such service.

In many practical efforts to promote community mental health, emphasis is placed more and more on social situations and relationships. For instance, in promoting

* Eugene E. Levitt, Helen R. Beiser, and Raymond E. Robertson, "A Follow-up Evaluation of Cases Treated at a Community Child Guidance Clinic," *American Journal of Orthopsychiatry*, Vol. 29, No. 2 (April 1959), pp. 337-346; E. E. Levitt, "The Results of Psychotherapy with Children: An Evaluation," *Journal of Consulting Psychology*, Vol. 21, No. 3 (June 1957), pp. 189-196.

¹⁹ Hyman M. Forstenzer, "Role and Responsibility of Social Work in Community Mental Health Programs." Paper presented before the Section on Psychiatric Social Work at the annual meeting of the American Psychiatric Association, May 1958.

²⁰ Luther E. Woodward, "Social Health—An Increasing Dimension in Orthopsychiatry," *American Journal of Orthopsychiatry*, Vol. 27, No. 3 (July 1957), pp. 445-461.

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mental health in schools, attention is shifting away from spotting and counting deviant children toward removing school blocks to mental health for all children—blocks often made up of the school's own organization: impossibly large classes, unhygienic attitudes of some staff members, undemocratic procedures in administration, exposure of children to too much or too little stimulation, prejudicial community attitudes that infiltrate the school, too wide differences between the expectations of parents and teachers and other conditions that create conflict or impede social learning.²¹

Mental health boards and community clinics are giving consultative service to allied professionals who have face-to-face relationships with people in some helping capacity, such as the general medical practitioner, the clergyman, the teacher, the public health nurse. Such consultation, especially when supplemented by systematic in-service staff education, enables allied disciplines to increase their contribution to the mental health of the people with whom they normally work, and results in more selective referrals to therapeutic agencies.

There are efforts in many hospitals to study and improve staff-patient relations. A number of unpublished and published reports seem to agree that the usual authoritative hierarchical system and the relatively low level of real trust and respect for patients (for whom the whole hierarchical scheme is theoretically established) leave much to be desired.²² It takes more than one-to-one relationship—over a wide and

unbridged status difference—to provide maximal help to the mentally or neurotically ill. The relation of the patient to the ward attendant, the lay visitor, and to other patients has assumed new significance. Individual health cannot be fostered in a hospital or clinic without providing a socially healthy situation. The whole movement toward open hospitals and stepped-up community programs relies heavily on making extensive therapeutic use of relationships of patients to patients and of patients to other persons in the community. As Dr. T. P. Rees has stated: "Patients take much more notice of what their fellow patients say than what the doctors tell them or the nurses tell them. Every patient wants to stand in good light with the other patients. It is much more important for the other patient to think well of them than the nurses or doctors to think well of them."²³ From Dr. Rees's descriptions, recovery seems to come about from patients' concern for other patients and the common sharing in a full program of occupation, recreation, and social living. Reversing Lawrence Frank's famous phrase, "society as the patient,"²⁴ we are learning that it is equally true that patients are a society and that their group life can be so organized as to constitute a health-inducing society.

The rapid development of group therapy or guidance in hospitals, clinics, and social agencies in the last few years not only makes some help available to larger numbers of people, but capitalizes on the healthy features in the lives of patients. In the group, many patients seem more easily to recognize their own projections and evasions, and also to discover their inherent strengths and personal resources for solving problems and relating more effectively to others.

We have mentioned earlier the possible

²¹ Mental Health Committee of the State Education Department, *Removing Blocks to Mental Health in School* (Albany, N.Y.: New York State Education Department, 1954).

²² Milton Greenblatt, Daniel J. Levinson, and Richard H. Williams, *The Patient and the Mental Hospital* (Glencoe, Ill.: The Free Press, 1957); Alfred H. Stanton and Morris S. Schwartz, *The Mental Hospital* (New York: Basic Books, 1954); Ivan Belknap, *Human Problems of a State Mental Hospital* (New York: McGraw-Hill Book Company, 1956).

²³ T. P. Rees, "Discussion Before New York City Community Mental Health Board," November 7, 1956. (Mimeographed.)

²⁴ Lawrence K. Frank, *Society as the Patient* (New Brunswick, N.J.: Rutgers University Press, 1948).

extensions of work within hospitals and in connection with them. By extending the social dimensions in mental health work in these several ways social work can be more helpful to more people, and strengthen its ties significantly with kindred helping professions.

NEW THEORY NEEDED

While research in this field has not yet achieved any high level of accomplishment, we can begin to move toward positive social health by applying a research approach to the causes of social disturbance, to the planning and measurement of services, and to basic education and social action.

Impressive in recent studies—both of mental illness and of education, including parent education—is the great significance of social class differences. In the Hollingshead and Redlich studies in New Haven the incidence of psychosis is shown to be much higher in the lower classes than the relative incidence of neurosis, and vice versa with the higher classes.²⁵ But what is perhaps more significant is that the usual helping professions—psychiatry, psychology, and social work—neither understand nor are able effectively to treat members of the lower social classes. They obviously do not understand the value systems or motivations for adjustment and maladjustment in the lower classes.

Why has the social work profession produced so little by way of psychosocial theory? Surely we have not dissipated all our intellectual energies on differences between the functional and diagnostic schools! What other profession has had so much concern about, or firsthand contact with, social class differences and the possible relation between these differences and people's illnesses and social problems? It is regrettable that when the profession took such a strong psychological turn, a quarter-century ago, it did not maintain with equal vigor its own sociological perspective. How different our

profession might be today if most social workers, instead of adopting rather uncritically this or that school of psychoanalysis (whose psychological theory and therapeutic methodology were developed in treating neurotically ill persons without much regard for their cultural and social class differences), had suspended even briefly the search for Oedipal conflicts, castration fears, and death wishes to concentrate on trying to understand the differing value systems, goals, and expectations that enter into decision-making and reality testing, and the discouragements and despair that result in drifting or defeat. We might have learned long ago, for instance, what is now being said by Dr. William C. Kvaraceus and associates in the progress report on their study of juvenile delinquency: that people in the lower social classes are trouble-oriented primarily, and that for the lower-class delinquent the child guidance clinic is not the pay-off route.²⁶ We have also surely known that middle classes are "oriented to achievement and to cleanliness" and need not have gone on as if on the assumption that all people, in all social classes and springing from diverse cultures and subcultures, are similarly oriented.

NEW INVENTIONS NEEDED

Social work produced the family and children's casework agencies, partly as substitutes for the older congregate institutions for orphans and for aging people. It produced group work agencies for education, recreation, and the indirect promotion of health; it helped to invent the community clinic, and more recently has helped to produce the residential treatment center. It currently has a small hand in the experimental development of day care programs for very disturbed children, and therapeutic nurseries. It also had a fairly active part in producing two of our major modern social inventions: social security and com-

²⁵ August D. Hollingshead and Fredric C. Redlich, *Social Class and Mental Illness*, *op. cit.*

²⁶ William C. Kvaraceus, *et al.*, *Delinquent Behavior: Culture and the Individual* (Washington, D.C.: National Education Association, 1959).

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munity chests and councils, both of which in quite different ways are concerned with all the people. Yet how few new social inventions the profession of social work has, in fact, produced!

When as much energy is put into the planning of mental health services—with as much astuteness for social and community features—as into “psychodynamics” in the past, we will probably *invent* more effective means of aiding the large numbers of people now in mental or emotional distress. Emphasis will have to be on invention, for a whole set of problems has developed about the concept that in order to solve some of our dilemmas we need “more of the same”—that we need simply to bring existing methods, structures, and agencies into areas where they have not previously been available. In some instances this may be the answer, but in many communities something we do *not* need is the assumption that the way we have been doing things is adequate and that our new and changing communities simply require extension of the old patterns. Current changes both in the central cities and in the countryside call for adaptation, not only of administrative structure and modes of community organization and so forth, but also in our very concepts of community. While the population is making its own adaptations, despite stresses and strains, we should be more aware of them ourselves and likewise make adaptations in our professional planning and practice.

One area where much sharper thinking is required is in the field of child behavior problems. The tendency to view any child who violates the law or our moral codes as being a psychiatric problem best treated by classic clinical methods needs critical re-examination in the light of the problems precipitated by the changing community. We should be approaching our current problems by marshaling our social resources rather than by seeking the application of more clinical procedures. To many this has been sufficiently obvious, and we have

the pronouncements, but not the action, to accomplish necessary adjustments by better co-ordinating and regrouping our resources. A major need is to apply social research methods to measuring the outcome of services given, and to planning facilities.²⁷

Last, it may be noted that along with the prevalent doctrine of therapeutic necessity has gone a vicious counterpart, that of educational futility. We rather naïvely assume that everybody who is less than what someone thinks he ought to be needs therapy to make over his personality. Conceivably, his education in vital matters may be as much enhanced by appropriate efforts as our own professional education by attending lectures, workshops, and seminars in university centers. Certainly many people are educable in ways that matter to them, or our educational institutions would not be bursting at the seams as they are; there is reason to believe that they are educable in reference to family, money, jobs, and health, which comprise their main areas of worry or tension and social work's chief areas of concern in planning and giving service. We are learning, however, through a variety of research studies—notably in the education of parents—that the amount and kind of learning that goes on is closely related to social class differences, upward mobility or lack of it, and the kinds of people who are the reference persons in their lives.²⁸

In short, we are at last learning that education is effective only when the educational process is conceived in social terms, and when educational content and methods are consonant with the specific social goals and strivings of the group.

²⁷ Bradley Buell, *Is Prevention Possible?* (New York: Community Research Associates, 1959).

²⁸ Daniel R. Miller and Guy E. Swanson, *The Changing American Parent* (New York: John Wiley and Sons, 1958); Orville G. Brim, *Education for Child Rearing* (New York: Russell Sage Foundation, 1959); David Mann, Luther Woodward, and Nathan Joseph, *Report on Research in the Education of Expectant Parents* (Visiting Nurse Service of New York, to be published in 1960).

BY MYRON J. ROCKMORE

Social Work Responsibility in Mental Illness

THIS PAPER WILL consider some aspects of the problem of those who return to communities after hospitalization for mental illness, that is, the social work problem. At a minimum it has been estimated that for the country as a whole a quarter of a million persons and their families are involved every year.¹ It poses a sizable problem for any community, one that has historically been an area of primary social work interest, one that is worthy of all the technical preparation a social worker can get.

EARLY HISTORY

As early as the 1870's, the Conference of Charities and Corrections became concerned with the provision of facilities for the indigent insane; social agencies were also beginning to find that they were a primary resource in looking after families whose breadwinners became incapacitated through mental illness. Twenty years of public pressure produced the New York State Care Act of 1890, an objective of which was to remove the insane from almshouses; it also provided for state support of the indigent insane. In the 1890's the New York State Charities Aid Association developed a Committee on the Insane, whose purpose was "To inaugurate and maintain a system of after-care for convalescents leaving a mental hospital." Some years later (1906) they demonstrated the service by subsidizing a

social worker to follow cases discharged from Manhattan State Hospital. In 1911, the state took over the program. Mr. Folks, secretary of New York State Charities Aid, delivered a stirring human plea for after-care services to the Conference of the State Hospital Commission, State Hospital Managers and Superintendents in September, 1913.² It took New York forty years more to develop his concept of "a local station . . . in the larger centers of population."

This period of historical development contains the seeds of the issues with which social workers are still engaged. It can be traced through professional education from 1898, or through the child guidance movement, which began in the juvenile courts as early as 1901. It was not until twenty years after the birth of professional social work education that Smith College identified a psychiatric social work sequence, followed the next year by the Commonwealth Fund Program for the Prevention of Delinquency, which gave impetus to the establishment of child guidance clinics.

This early period also saw the introduction of Freud's discoveries into this country, which has been brilliantly chronicled by Maurice R. Friend,³ who casts the

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¹ Myron J. Rockmore and Elias J. Marsh, "Community Planning as a Support to Treatment," *American Journal of Psychiatry*, Vol. 116, No. 8 (February 1960).

² Homer Folks, "After-Care of the Insane—with Special Reference to the Establishment of Out-Patient Departments," *State Hospitals Bulletin*, Vol. 6, No. 3 (November 1913).

³ Maurice R. Friend, M.D., "The Historical Development of Family Diagnosis," *Social Service Review*, Vol. 34, No. 1 (March 1960).

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currently popular "family diagnosis" in proper context. Implicitly, the historical threads of social work and the medical specialty of psychiatry are interwoven, sometimes as a patchwork, sometimes as a pattern. By the 1920's, social work and psychiatry were beginning to work together in a period of clinical endeavor. Schools of social work were turning out graduates attuned to communication with psychiatry, who were staffing the child guidance clinics. The curriculum was being enriched by "The Nature and Varieties of Human Behavior" and "The Mental Hygiene Problems of Childhood." Healy and Bronner, Lee and Kenworthy were on the library shelves⁴ and the American Association of Psychiatric Social Workers appeared on the scene to make a lasting contribution to generic social work training as we know it today.

The economic upheaval of the 1930's resulted in a tremendous development of social legislation which enunciated and implemented the concept of public responsibility for common basic human needs. Voluntary agencies moved through a turbulent period of recasting their functions. Century-old agency names changed, with "community service" replacing "charity." Voluntary agency intake focus shifted from "What are your needs?" to "What is your problem?"

The 1940's brought a war and tremendous population mobility. The dramatic reality fused "problems" and "needs" so that they became less easily distinguishable. Reality threats were manifest—anxiety was more often true than neurotic. Child guidance clinics went into long pants as military mental hygiene units.⁵ AAPSW

created a War Service Office. USO, Red Cross, Travelers' Aid, UNRRA recognized problems and met needs. The problems were reality-based; more frequently than not the needs were reactively emotionally determined. There was usually no technical reason to ask why or what it meant to a young wife to want to be near her husband, or not to offer supportive help to children who were showing symptomatic reactions in the face of uncertainty they could not be expected to comprehend. More important was assistance to help work out the arrangements, or to listen to the limitations which for the time being were to be recognized and borne. Psychoanalysis moved toward its superstructure of ego emphasis, developing insights which led to broad casework adaptation.⁶ As the atom was smashed, Anna Freud broke through the self-limiting concept of maternal rejection.⁷

The 1950's closed with the development of community services, both clinical and "adjustment," as one of the major social work trends. The contribution of Bradley Buell,⁸ the beginning of *rapprochement* between psychiatry and public health, the public assumption of responsibility for community mental health programs, and the wave of "open" mental hospitals, all came into the picture. It is to be hoped that the 1960's will be marked by planning efforts to bring to fruition a depth of service which utilizes more than a fraction of what social workers know.

ISSUES BEGIN TO EMERGE

As public programs assumed responsibility for a basic decent standard of living, volun-

⁴ William Healy and Augusta Bronner, *Reconstructing Behavior in Youth* (New York: Alfred A. Knopf, 1929); William Healy and Augusta Bronner, *Delinquents and Criminals* (New York: The Macmillan Company, 1926); Porter R. Lee and Marion E. Kenworthy, *Mental Hygiene and Social Work* (New York: Commonwealth Fund, 1929).

⁵ H. L. Freedman, "The Unique Structure and Function of the Mental Hygiene Unit in the Army," *Mental Hygiene*, Vol. 27, No. 4 (October 1943).

⁶ Heinz Hartmann, "Comments on the Psychoanalytic Theory of the Ego," *Psychoanalytic Study of the Child*, Vol. 5 (New York: International Universities Press, 1950).

⁷ Anna Freud, *Safeguarding the Emotional Health of Our Children: An Inquiry into the Concept of the Rejecting Mother* (New York: Child Welfare League of America, 1955).

⁸ Bradley Buell, *Community Planning for Human Services* (New York: Columbia University Press, 1952).

tary agency practice moved toward the new insights revealed in the treatment of neurosis. Intake became more and more selective, and so preoccupied with technical problems that sometimes it has been difficult to know whose needs were being served—those of the agency (the professional leadership) or those of the community (the people in trouble for whom the agency was developed).

The state hospitals, coming out of hibernation, struggled with the lag of thirty years' enforced isolation. Even recently hospital psychiatrists are reported as considering themselves responsible essentially for the patient during an acute phase of the illness with the accompanying and paradoxical attitude "that relatives should be cared for either by social service or by agencies not connected with the hospital."⁹ The pitifully inadequate hospital social work staffs and the variety of administrative avenues by which a patient returns to the community without supportive help add to the complex.¹⁰ Too frequently the official attitude is that the hospital emphasis is on pathology and clinical recovery—little or no consideration is given to the social factors that exacerbate the illness, or can be brought into play to mitigate its manifestations after or during remission. Notable exceptions are California's Bureau of Social Service and the New York After-Care clinics which in a number of cases are heroically pointing the way. The sheer volume of patients, however, is such as to make these efforts seem discouraging in the face of mounting rates of readmissions.

Communities have increasingly come to recognize the impact of mental illness on

their families in trouble—in courts, welfare case loads, schools, general hospitals, and other health and welfare agencies. The mounting concern for our aging population is another factor which cuts across this No. 1 public health problem. Lay leadership which sponsors and supports public and voluntary agencies prods us as the pinch and scramble for funds continue.¹¹ Only the heavily endowed agency can afford—literally—to define a function solely in terms of professional interest. The fantasy that more staff and more service can be supplied by additional funds has been shattered through objective data.¹² As we appear before legislative or chest budget committees, we shall be called upon more and more to justify our requirements in terms of the way in which we are meeting pressing community needs.

In the face of this, a study of the employment status of 903 social workers trained under Public Health Service traineeship grants from 1948–1956 revealed that only 39 percent were working in psychiatric settings (only 19 percent in hospitals!). The AAPSW Research Study of almost ten years ago revealed an overwhelming percentage of trained social workers in community services as opposed to hospitals.¹³ Thus our most highly trained practitioners are in services in which there is small chance that the ex-hospital patient will be served. Repeatedly, at the recent annual conference of the Milbank Memorial Fund, speaker after speaker posed the problem of co-ordination of services—how does one develop the spec-

¹¹ Sidney Spector, *Tax and Fiscal Policy and State Mental Health Programs*, Monograph Series No. 5, APA Mental Hospital Service (Washington, D.C.: American Psychiatric Association, March 1959).

¹² Daniel Blain and Robert L. Robinson, "Personnel Shortages in Psychiatric Services—A Shift of Emphasis," *N.Y. State Journal of Medicine*, Vol. 57, No. 2 (January 15, 1957); George W. Albee, Ph.D., *Mental Health Manpower Trends* (New York: Basic Books, 1959).

¹³ Tessie D. Berkman, *Practice of Social Workers in Psychiatric Hospitals and Clinics* (New York: American Association of Psychiatric Social Workers, 1953).

⁹ L. C. Deasy, and O. W. Quinn, "The Wife of the Mental Patient and the Hospital Psychiatrist," in John Adam Clausen and M. J. R. Yarrow, eds., "The Impact of Mental Illness on the Family," a symposium, *Journal of Social Issues*, Vol. 11, No. 4 (1955), pp. 3–64.

¹⁰ M. J. Rockmore and R. J. Feldman, "The Mental Hospital Patient in the Community," *Mental Hygiene*, Vol. 40, No. 2 (April 1956).

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trum of services from the community to the state hospital and return? How is responsibility picked up and passed along from agency to agency—from clinical to nonclinical services?¹⁴ Here is a problem calling for the highest priority.

ATTEMPTS TO MEET THE PROBLEM

Studies reveal that social agencies have little part in the process by which admission to state hospitals is accomplished.¹⁵ The resistance of agencies to accepting referrals of hospital discharges is well known—the assumption is that the hospital will have continued responsibility after their release.

Some communities are in the planning stages of programs which address themselves to the problem. One example involves joint planning by a state hospital, a family agency, and a psychiatric outpatient department of a general hospital. They hope to demonstrate that community-based agencies can provide an effective program of rehabilitation for the mental hospital patient who is discharged, or on an extended visit, and returns to his community. Interestingly enough, this project is sponsored by a local council of social agencies and was developed with the state department of mental health. Another involves a state hospital and a Visiting Nurses Association. The VNA is the moving agency with the participation of the state department of mental health, the local mental health association, and the local council of social agencies of which it is a member. Here the objective is to determine the criteria of cases in which the services of this professional group can be effective. Both projects were stimulated by community concern, crystallized by informed lay leadership, and implemented by

courageous executives actively moving toward articulated community need. They illustrate a real potential in joint public and voluntary effort.

A recent conference of State Chief Social Workers in Mental Health Programs considered efforts that have been made toward mobilizing community resources.¹⁶ Among them were a project in Florida for coordinating the social agency efforts in one county to serve discharged state hospital patients; a Kansas preadmissions team of social worker-psychiatrist to facilitate admission or prevent it through the intervention of community services; the utilization in Wisconsin of psychiatric social work consultants in the welfare department as community planners, co-ordinators, and educators. Furthermore, councils of social agencies who distribute the contributor's dollar have moved into the picture, as for instance in Baltimore, where they have been studying admissions processes to hospitals and the use of police. All these efforts augur well for future planning.

Addressing oneself to community need is no simple task, since much depends on who is doing the defining, or what forces emphasize what aspects of whose needs. Any council or committee whose purpose is to identify gaps in community resources, or to determine agency responsibilities with regard to agreed-upon, unmet needs for services, can attest to the difficulties of this task. The dynamics of the conference table defy the most astute clinician. Each locale and each purpose have an individual set of determinants. Frequently informed lay leadership is missing in these attempts to relate to community need, yet without it there is danger of narrowing the definition to professional community need. Laymen have a refreshing way of asking us to cut across our functional barbed wire fences and come up with answers to problems!

¹⁴ *Progress and Problems of Community and Mental Health Services* (New York: Milbank Memorial Fund, 1959).

¹⁵ John Adam Clausen and M. J. R. Yarrow, "Paths to the Mental Hospital," in Clausen and Yarrow, "The Impact of Mental Illness on the Family," *op. cit.*

¹⁶ Twelfth Annual Conference of Chief Social Workers from State Mental Health Programs, Chicago, Ill., February 22-24, 1960.

SOME TECHNICAL PROBLEMS

For some years now agency psychiatric consultants have infused social work practice with theoretical material. Too often they are still in the early or middle stages of their own training. Too often they are cast in a role of omniscience, and are expected to supply answers beyond their capacities even if they had the benefit of long individual work with the particular case in question. In our eagerness to know more and better how to serve our clientele we assume that the consultant and ourselves have the same professional responsibility for our client, *who is not his patient*. Although our long-range objectives, *i.e.*, a more satisfying life adjustment for the people we attempt to help, may be similar, we must be more modest in what we try to do. We must maintain our interest in the individual and the individual's problem and find ways in which we can be of help to him. We must use our theoretical knowledge of unconscious motivation to eliminate repeatedly unsatisfying solutions. We must appreciate more fully the usefulness of symptoms, of the potential for reality adaptation in humans, and the fact that no therapy can compete with a satisfying life's experience. These are but a few avenues to travel in developing an appreciation of the strength of social work practice in assisting people with problems. Through social work programs, the lives of millions of people are influenced—in June 1958 the number of persons served by all public welfare agencies was 6,300,000 and the cost *that month* for assistance, service, and care was \$290 million.¹⁷ Through our agencies we can help individuals relate more constructively to their difficulties if we recognize the limitations of our training, circumscribe our objectives, and relate primarily to the strengths in the personalities and families of our clients.

¹⁷ Remarks by Harry O. Page, *Progress and Problems of Community Mental Health Services*, *op. cit.*, pp. 112-115.

Charlotte Towle has said it well:

Today, our social work self is being revived; in fact, it constitutes the "new" in social casework. In rediscovering family-centered casework, we no longer see the psychodynamics of family life largely as a means to understanding and coping with the individual's pathology. These insights are now considered essential for helping an individual with close reference to those in relationship to him for his benefit and for the welfare of the family group.

Very important also is our rediscovery of the validity of differential relationship oriented to the client's need and capacity rather than to our own need to enact a prescribed therapeutic role. We have been refinding our own style in our casework focus and treatment emphasis rather than emulating the psychoanalyst's style. Although we are still guided by psychoanalytic understanding, we are challenged anew by the knowledge and skill entailed in the competent performance of our comprehensive function as social workers. There is no ego-deflating simplicity in the return of the social component into casework practice.¹⁸

Thus we are coming full circle. Mary Richmond gave us a conceptual systematic method; Marion Kenworthy's case analysis method (the ego-libido chart) gave us direction. Psychoanalytic investigation continues to give us understanding which we have difficulty in transposing into our practice.

This is reminiscent of an intuitive interpretation of the late Ernst Kris. Freud was on the verge of discovery in his analysis of Dora when she interrupted the analysis. Kris offered the possibility that Freud's interest in his impending theoretical formulation was sensed by his analysand. She interpreted this as a lack of personal interest—an exploitation of her or a rejection of her personally, and left him. Freud

¹⁸ Charlotte Towle, "Marion E. Kenworthy: A Social Worker's Reflections," *Social Service Review*, Vol. 30, No. 4 (December 1956).

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attributed the interruption to his lack of understanding of the transference. It needs repeating that analysis was primarily conceived as a research technique, that interest in the analysand is essential to understanding the forces which shape his personality, that therapy and therapeutic results are by-products of the investigatory process. This insight may be useful to social caseworkers today, for if we listen more closely to our clients, we may be able to tailor our casework services closer to their wishes and to the community's needs—and less to our technical interests. Here may be some clues to the high rate of attrition in children's and adult community clinics where patients withdraw from service without knowledge or participation by the clinic.¹⁹

We must look to the practitioner for answers to our technical questions. Our social work educators, our administrators, our sponsors all converge on a single objective—the creation of method and skill in a setting with a climate where a service can be rendered. It is in the interview, the group session, the interagency conference, the research design that we find the crucible which tests our craft. The practitioner has the opportunity to apply the method, develop the skill, experiment, evolve an hypothesis, test it out, revise it, and learn from his experience. At best our professional preparation offers us a framework to start practice. From that point we need to reach out, albeit empirically, beyond the limitations of our teachers. Their objectives and confines—professional ego boundaries, if you will—are different from our own. We see this when we function as field work instructors and hew to educational objectives which may produce points of friction with agency objectives. It is speculative, but it may be suggestive, that the field work

training function of an agency may condition its flexibility and limit its creativity—a negative corollary to a positive agency asset. These may be ties that bind—our professional strength which is our baseline of operation may contain the seeds of our timidity! Instead of looking to our preceptors for an evaluation of our efforts we may be looking for directions from them which can only be supplied by our clients, who will tell us if we serve them.

REDIRECTION OF SERVICES

The writer suggests that the voluntary agency give returning mental hospital patients a No. 1 priority. At intake social workers are assured a psychiatric diagnosis—they are offered a problem of social readjustment. They are faced with family disequilibrium. They are also presented with the possibility of dramatic affirmative results with the techniques that are within their training and competence. Social workers who have spent their careers with mental patients can attest to this. Some pioneering agencies are finding this a worthwhile task. In St. Paul, at the Family-centered Project, it is reported that the prognosis of a case is *more hopeful when a spouse has suffered from psychosis than when a problem of prolonged marital conflict exists. A study of cases considered failures did not include a single parent who had been found to have a history of being psychotic!*²⁰

It has been predicted that before too many years the trend toward voluntary state hospital admission will make the involuntarily committed patient a small percentage of the total resident patient population. At such time, even more so than now, the question of functional responsibility will be of secondary importance. Of principal importance will be the needs of the case vis-à-vis the agencies' ability and willingness to meet these needs where the

¹⁹ Jacob Tuckman and Martha Lavell, "Attrition in Psychiatric Clinics for Children," *Public Health Reports*, Vol. 74, No. 4 (April 1959); Hyman M. Forstenzer, Director, Community Mental Health Service, New York State Department of Mental Hygiene, report for year ending March 31, 1959.

²⁰ Katherine H. Tinker, "Casework with Hard-To-Reach Families," *Journal of Orthopsychiatry*, Vol. 29, No. 1 (January 1959).

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client is—in the community. This will require joint policy planning at the administrative levels from which case-planning can flow at the practice levels. Hospital administrations will have to maintain continuous open channels of communication with health and welfare agencies, both voluntary and public. Community facilities will have to increase their insistence on information regarding the numbers and problems of patients coming from their area who are admitted to and separated from hospitals.

Through such interchange it will be possible to develop guidelines for the assumption of continued responsibility by the various resources. If the needs of the case are

essentially medical (psychiatric), the primary responsibility would lie with the appropriate after-care clinic or general hospital outpatient department. If the needs of the case are essentially in the area of social readjustment or involve categorical assistance, the appropriate public or voluntary agency should carry the ball. This oversimplification is made only to illustrate the importance of setting up machinery at the top levels to insure a case-planning method that will relate to the needs of the patients, to determine whether they are to continue to be patients or have improved to the point where they can be considered clients and can be treated as such.

This shift (from "patient" to "client") is not merely a matter of semantics. It presumes a difference of professional training and a difference of a sense of public and social responsibility. It presumes that:

—Generic social work training has given us some understanding of psychopathology and we can relate to the problems people bring to us, regardless of the degree of their personality disturbance,

—We can be of help to people without assuming responsibility for their medical needs beyond recognizing them with our clients and attempting to facilitate their contact with an appropriate medical resource,

—The medical profession has the responsibility for medical diagnosis and the determination of the need for hospitalization, release from the hospital, or rehospitalization.

These principles establish a sound basis for interprofessional co-operation. It remains for us to apply them to extend the service of which the social work profession is capable.

BY SYDNEY E. BERNARD AND TOARU ISHIYAMA

Authority Conflicts in the Structure of Psychiatric Teams

INCREASING INTEREST is being shown by some state hospitals in a sociotherapeutic approach. This approach does not localize the therapeutic agent in any one person or group of persons, such as is implicit in the psychotherapeutic approach.¹ The sociotherapeutic orientation views as potentially helpful not only the formal treatment programs of the hospital and its personnel, but also the total social structure of the hospital. The hospital is viewed as a network of personal relationships in which the patients, who make up a large part of the network, participate socially and share certain values common to that network. The patient's behavior, therefore, is not viewed solely as a function of his individual personality and pathology, but partly as a function of the hospital situation.² The goal of the sociotherapeutic orientation, then, is to provide procedures and patterns of functioning and situations which will facilitate the therapy potential of the hospital, employees, and patients by structuring a rationally organized, internally consistent, and treatment-oriented social system. This system must consider the needs, skills, and potentials of the staff together with those of the patients.

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The sociotherapeutic orientation thus embodies two insights. First, that all factors, external as well as internal to the patient, must be made a vital and positive part of the treatment program. Second, that this orientation is too complex to be effectively executed by any one person or profession.

To gain a full understanding of all the forces outside the patient that affect his treatment would require the widest possible focus. Stanton and Schwartz made clear the need to study the various ways in which institutional social structures affect patient treatment.³ Loeb points out the incongruity between the formal hospital table of organization and the informal social structure, which often presents a quite different status hierarchy.⁴ This incongruity is noted to have very definite effects on staff communication and on staff treatment efforts. Other studies point to the relationships between treatment ideology, role definition, and personality, and the relation-

¹ Myron R. Sharaf and Daniel J. Levinson, "Patterns of Ideology and Role Definition Among Psychiatric Residents," in Milton Greenblatt, Daniel J. Levinson, and Richard H. Williams, eds., *The Patient and the Mental Hospital* (Glencoe, Ill.: The Free Press, 1957).

² Esther L. Brown, H. Warren Dunham, and Richard H. York, "The Application of the Sciences of Social Behavior in Ward Settings," in Greenblatt et al., *ibid.*

³ Alfred H. Stanton and Morris S. Schwartz, *The Mental Hospital* (New York: Basic Books, 1954).

⁴ Martin B. Loeb, "Role Definitions in the Social World of a Psychiatric Hospital," in Greenblatt et al., *op. cit.*

ship between treatment ideology and social class membership.⁵

The purpose of this paper is to analyze one segment of this complicated field. A sociotherapeutic orientation imposes definite and often predictable stresses on interpersonal relationships. These interpersonal relationships can involve staff-staff, patient-patient, or staff-patient interactions. We will focus on staff-staff relationships, point out some conflict situations, discuss their implications, and make some tentative suggestions toward their mitigation.⁶

When any disparate group begins to work together, areas of conflict will emerge. To a

⁵ Fred Pine and Daniel J. Levinson, "Two Patterns of Ideology, Role Conception and Personality Among Mental Hospital Aides," in Greenblatt *et al.*, *op. cit.*; Sharaf and Levinson, *op. cit.*

⁶ Role has come to assume a central position in the analyses of these interrelationships. Descriptive studies have pointed out the roots of these relationships in the history, training methods, and present status of the various mental health professions. See Alvin Zander, Arthur S. Cohen, and Ezra Stotland, with the collaboration of Bernard Hymovitch and Otto Reidl, *Role Relations in the Mental Health Professions* (Ann Arbor, Mich.: Research Center for Group Dynamics, Institute for Social Research, 1957). The challenge posed by psychiatric settings and the difficulties in meeting this challenge are discussed by Irving Weisman in an article, "Impact of Setting upon Social Workers and Patients," *Social Work*, Vol. 2, No. 3 (July 1957), pp. 70-76. Merton presents a theoretical groundwork for a discussion of the difficulty in effecting a changed role within a bureaucratic setting (Robert K. Merton, "Bureaucratic Structure and Personality," in Herman D. Stein and Richard A. Cloward, eds., *Social Perspectives on Behavior* [Glencoe, Ill.: The Free Press, 1958]). Problems arising out of the need for a changing role are analyzed by Schwartz for psychiatric nurses and Ohlin *et al.* for social workers (Charlotte Green Schwartz, "Problems for Psychiatric Nurses in Playing a New Role on a Mental Hospital Ward," in Greenblatt *et al.*, *op. cit.*; Lloyd E. Ohlin, Herman Piven, and Donnell M. Pappenfort, "Major Dilemmas of the Social Worker in Probation and Parole," in Stein and Cloward, *op. cit.*). An inherent contradiction in the authority relationships of psychiatric team members is outlined by Siporin, who offers some administrative methods to clarify if not resolve this dilemma (Max Siporin, "Dual Supervision of Psychiatric Social Workers," *Social Work*, Vol. 1, No. 2 [April 1956], pp. 32-42).

staff group implementing a sociotherapeutic orientation this area produces such questions as, "Who is competent to make decisions in areas which are not clearly within the traditional competence of the various disciplines?" The following discussion concerns conflicts occurring in areas of decision-making in which the responsibility for the decision is desired by two or more disciplines, or in which each of the participants demands that the other assume this responsibility, and is derived primarily from our experience at Cleveland State Hospital, where a sociotherapeutic approach has been evolving for the past few years. These observations were arrived at largely independently by the two authors, and are based on varied experiences at the hospital, including working on teams (but not the same team), supervision of other staff members, and discussion with various colleagues.

THEORETICAL FORMULATION

In order to provide a theoretical basis for this discussion we will employ the central concept of *role*. Personality, job demands, and professional role are three major components of this concept. They, in turn, lead to the variables: motivation, assigned role, and achieved role. The assigned and achieved roles are further reduced to assigned and achieved authorities, respectively. The interplay of motivation, assigned authority, and achieved authority form the framework of our analysis.

Role is defined here as: *A collection of patterns of behavior which are thought to constitute a meaningful unit and deemed appropriate to a person occupying a particular status in society. . . . Role refers to behavior rather than position. A complex collection of behavior is expected from ourselves and others when we play certain roles.*⁷

To fulfill a role which is understood by

⁷ Ralph H. Turner, "Role-taking, Role Standpoint and Reference Group Behavior," in Lewis A. Coser and Bernard Rosenberg, eds., *Sociological Theory* (New York: The Macmillan Co., 1957).

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others and mastered by the individual offers an ease of communication and a security of relationships not easily forsaken. Role-ambiguity, however, is the rule in the situations we plan to discuss. As the staff members strive to resolve this ambiguity and its attendant anxiety, their reactions can be analyzed in terms of the interaction of the three variables noted above. In general terms they are: personality of the individual staff member, job demands of a specific setting, and professional role of the individual staff member. To the individual they are experienced as his motivation, assigned authority, and achieved authority.

Personality may be defined in various ways, depending on the kind of theoretical orientation one assumes. For our purposes we are merely referring to all that the individual brings to his job in terms of his interests, aptitudes, attitudes, and the like. The manifestation of this personality which is crucial for our analysis we shall call *motivation*. Motivation is used here to refer to the individual's desire to move toward an object. What underlies the motivation will not be considered in our analysis. We are primarily interested in the intensity of the desire to undertake those activities that are deemed necessary for the establishment of a desired objective.

Job demands are inherent in any work setting. These demands are determined by the goals and purposes, techniques and organizational structure of the work setting. They are expectations imposed upon the individual. These expectations determine to a great extent the kinds of duties that he will perform, the degree of authority he will wield, and so on. These expectations are imposed by the administration, by fellow workers, and, in a hospital, by patients. The expectations may be implicit or they may be explicit. We shall define these job demands as being incorporated in the term *assigned role*.

The individual's role in any situation is not only a function of what is expected of him, but also a function of what the in-

dividual expects from the situation. This perception is greatly influenced by the individual's membership in a given profession or group. The "professional role" as promulgated by all the social institutions associated with a given profession is a powerful force in determining this expectation. Job satisfaction is often largely determined by the degree to which the individual feels his job approximates the "professional role." However, mere membership in a profession does not guarantee the assumption of the desired role. The individual must win the right to perform the desired functions, or conversely, to avoid the tasks he feels are outside his professional role.

The other members of the situation permit him to assume his desired role to the extent that he can prove that he is equipped to do so, or to the extent that they need him to assume that role. Furthermore, the "professional role" is seldom so well or so rigidly defined that no variation in perception is permitted. Consequently, the individual has a great deal of latitude in defining what he wishes his role to be. For our analysis, we will use the term *achieved role* to refer to what the individual wishes, is capable of, and is permitted to do.

For more valid comparability, we have translated assigned and achieved roles into terms of power: the ability to influence the action of others and to be independent of the influence of others. Thus, assigned role indicates how much formal authority one is assigned by the administration or by the fact of occupying a certain position, while achieved role indicates how much informal authority one is able to earn by the dint of one's abilities and drive. The degree of authority that one is assigned or that one can earn, then, can be fairly easily analyzed in the same terms as degree of motivation. Thus, while this discussion is ostensibly about intrastaff conflicts in general, we are actually referring to intrastaff and intra-individual conflicts engendered by certain configurations of motivation, assigned authority, and achieved authority.

DISCUSSION AND EXAMPLES

The introduction of a sociotherapeutic approach involved a relatively new kind of endeavor. Thus, there were those whose motivation was high; these were the individuals who advocated and were committed to the "new" approach. There were those whose motivation was relatively low; these were the individuals whose association with the new approach was not wholly voluntary. There were those with negative motivation; these were the individuals who did not wish to be associated with the new approach, but who, for various reasons, were assigned by administrative order. Since the sociotherapeutic approach was a new endeavor, the definition of roles was unclear, both on the part of the administration and on the part of the individuals themselves. The administration made some attempt to define the assigned role, but this definition was invariably ambiguous. The definition was based on the usual psychiatric hierarchy, but with such vagueness that it could not serve as an adequate authority structure. The administration's attitude was that "the individual staff member does that which he is most capable of doing." For example, responsibility for setting up patient governments might be the function of any team member. Who may initiate team consideration of such questions as transfer to other wards, leaving the hospital, and home visits was never clarified. Another area of ambiguity was the mode of staff interaction. Is the team structure to be democratic or hierarchical? Could one team member tell another what to do and how to do it?

The reactions of the team members to this ambiguous and anxiety-provoking situation can be analyzed by comparing the relative degrees of motivation, assigned authority, and achieved authority. What happens when motivation is greater than assigned authority, which in turn is greater than achieved authority? What happens when assigned authority is greater than achieved authority, which in turn is greater than motivation?

The permutations and combinations of these three variables are many. We shall give examples of just a few that we feel illustrate the pertinence of our variables.

1. *Assigned greater than Achieved equal to Motivation.*

A physician whose assigned authority indicated that he was to be the leader of a ward team was quite reluctant to assume that authority. He did not like to work with other disciplines, nor did he like to make decisions that affected the functioning of the other members of the team. He very much preferred working alone, and did not relish the idea of relinquishing responsibility to his co-workers. He was quite willing to let everybody do as he pleased, and in this way managed to relinquish a great share of his authority and responsibility. Although in fact these were relinquished, they still remained implicit in his assigned role in the perception of the administration, his co-workers, and patients.

Because of the physician's behavior, and because his co-workers adjudged his competence to be low, his achieved authority was consonant with his low motivation. This configuration did not appear to present any sustained conflict for him, since he resolved the incongruity between the three variables by negating the assigned authority. However, the situation presented frustrations and conflicts for his co-workers, since an important segment of their situation refused to function as they expected or wished. Interestingly enough, when this individual occasionally tried to enforce his assigned role, his co-workers resisted. Because his achieved authority was low, his decisions were not readily accepted. There occurred a great deal of jockeying for the relinquished authority on the part of the co-workers, with no clear-cut resolution, since the physician's assigned authority was not available to them.

2. *Assigned greater or equal to Motivation greater than Achieved.*

A physician whose motivation was rel-

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atively high, though not enthusiastic, was quite willing to assume the duties inherent in his assigned authority. Unfortunately, because of certain defects in his functioning, his achieved authority was relatively low. Because of his high motivation, he did attempt to provide the leadership consonant with his assigned authority. But because of his low achieved authority, his co-workers began to engage in maneuvers to circumvent his authority and to block many of his decisions, which they felt to be faulty. The physician began to experience a great deal of frustration and became very bitter toward his co-workers, accusing them of dragging their feet and of being obstructionists. His co-workers, on the other hand, felt frustrated because they could do nothing while the physician was so jealous of his authority, and since the blocking of his decisions was not really a resolution of the problem.

3. Motivation greater than or equal to Achieved greater than Assigned.

A psychologist whose involvement in and commitment to the sociotherapeutic approach was almost total, attained an achieved authority far greater than his assigned one. Because of the high motivation and achieved authority, his influence and judgment were perceived as being beyond his assigned authority. While this incongruity was not thought important by most of his co-workers, his influence was resisted by others who were acutely aware of his lack of assigned authority. The incongruity presented some problems for the psychologist. While motivation and achieved authority were fairly equal, one would predict that he would remain in the situation and attempt to change it. This occurred. He was constantly attempting to change the structure of the team. While his attempts were ostensibly based on his conviction that the team structure ought to be a more democratic one, it was fairly obvious that part of his drive was based on his need to bring his assigned authority into greater harmony with his motivation and achieved authority.

If, in the above situation, the interplay of variables had resulted in decreased motivation, it could be predicted that the psychologist would leave the situation. This happened in the case of a social worker, whose motivation and achieved authority were greater than his assigned authority. When his efforts to narrow the gap did not immediately effect a change, there occurred a decrease in motivation and subsequent termination of employment.

4. Assigned equal to Achieved equal to Motivation.

Obviously, the ideal situation would be that in which the three variables are of equal intensity. A case in point is a psychiatrist in whom the variables operated in relative congruence. While his assigned authority was great, his motivation was equally great. He was convinced that the sociotherapeutic approach would greatly enhance the treatment potential of the hospital. Furthermore, because of his extreme competence, his achieved authority was as high as the other variables. Thus, he functioned efficiently in the team setting, his co-workers were reasonably satisfied; intrastaff conflicts were kept at a minimum. However, it is obvious that in terms of a complex team functioning, where the operation of the variables takes on added dimensions because of the interplay of a number of individuals, the situation in which the variables are equal and stable for every individual can exist only as an ideal.

Examples 1, 2 and 3 illustrate the observation that discrepancies between the three variables usually lead to intraindividual and/or intrastaff frustrations and conflicts. Example 4 indicates that a relatively non-conflicted situation can exist when the variables are in relative harmony.

All the previous examples refer to *post hoc* analyses. The following example illustrates how our variables might be utilized in the assignment of team members.

A physician and a psychologist were assigned by the administration to form a

team. The configuration of variables for the physician was assigned authority greater than achieved authority greater than motivation, while the configuration for the psychologist was motivation greater than achieved authority greater than assigned authority. Since the physician, for various reasons, was not highly motivated, it fell upon the psychologist to make the initial moves to negotiate for the acquisition of necessary team members. In his negotiations, it became very apparent that the psychologist's choices were based primarily on his personal likings, with only secondary consideration given to other factors.

While it is important that team members like each other, this attribute alone will not suffice. In this case, because of the relatively low motivation of the physician, the burden of forming and maintaining the team will fall upon the shoulders of the psychologist, whose motivation is high. However, since the assigned authority necessary to guide the team belongs to the physician and not to the psychologist, and since the psychologist's achieved or potential achieved authority is not great enough to make up the deficit in authority, the psychologist will eventually face the predicament of not being able to bring about certain necessary things. When this occurs, the psychologist may withdraw, with the subsequent regression of the team. However, if the psychologist can be given support, the withdrawal may be prevented. Such support might come from the other members of the team. According to our analytic framework, such support can come, for example, if the configuration of variables for the social worker were motivation greater than achieved equal to assigned. Because of the relatively high motivation of the social worker, he would be committed to establishing a well-functioning team, and because his assigned and achieved authorities are in harmony, he would support rather than compete with the psychologist. If the configuration were motivation equal to achieved equal to assigned for the social worker, there would be a satisfactory equilibrium for him and

therefore no drive to support the psychologist.

The foregoing analyses have been admittedly superficial. Factors such as sex, age membership in social class, and the like, are of great importance.⁸ We have, however, chosen to concentrate on three broad variables: personality, job demands, and professional role and their consequents of motivation, assigned authority, and achieved authority. The process of reduction resulted in the exclusion of many important aspects of personality, of specific job demands, and of the complexities of the achieved role. Some of these will be briefly touched on below.

Personality factors, other than motivation, will influence achieved and assigned authorities.⁹ An individual's achieved authority is greatly affected by the kind of response he is able to elicit from others. A technically skilled and knowledgeable, but officious, psychologist may not gain as much achieved authority as another who has less technical skill and knowledge, but is more likable, whatever the basis for this quality may be.

The assigned authority is not determined merely by a profession's position in the hospital hierarchy. One social worker may be assigned greater authority than another because of greater experience, greater skills, or simply because he is generally more aggressive in demanding authority.

How one reacts to a discrepancy between assigned and achieved authorities is not a function of motivation alone, but of many other personality factors. Of two recreation therapists with equally high motivation, one may persevere in efforts to achieve a satisfactory resolution; the other may quickly withdraw.

The job demands vary from situation to situation. Job demands in a situation of

⁸ For further discussion see Loeb, *op. cit.*

⁹ Some of these personality factors are referred to in Sharaf and Levinson, *op. cit.*, and Pine and Levinson, *op. cit.*

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high staff-patient ratio will differ from those in which the ratio is low. When the size of the team is small, the variety of duties one is expected to perform may be great, but the expectations in terms of intrateam interaction are relatively simple. When the team is large, the duties may be more limited, but the expectations in terms of intrateam interaction become complex. The distribution of authority in a situation where the team consists of a physician, a psychologist, and attendants will immediately change with the introduction of a nurse, a social worker, or an occupational therapist.

The achieved role is, as we have noted, determined by what one is "permitted" to do by others, as well as by one's wishes and capacities or abilities. Therefore, a clear understanding of the achieved role can be gained only with an analysis of the needs and abilities of all the components of the situation.

CONCLUSION

The foregoing considerations are important in the analysis of staff-staff interactions. Our analysis, however, has been based on pragmatic rather than scientific, or analytic, motivations. We were interested in isolating and defining certain gross and approximated variables which could be used to organize a relatively well-functioning team. More is necessary than the general impression that a certain group of people might be able to work together. The establishment of criteria, however gross, for the selection of a team may do much toward negating many of the initial and some of the later intrateam conflicts.

* Administration, department, and professional group all have a role to play in creating conditions that will help the individual in his task. The basic task of administration in forming a team is to keep in mind the total dimensions of the job to be performed, to choose team members appropriate for the task, and to assign au-

thority in line with job needs and the motivation and achieved authority of the individuals.

If the team is large and composed of representatives from a variety of disciplines, the assigned authorities may tend to be defined in terms of the traditional hierarchy of professions. If these definitions fit the needs of the situation, choices should then center on staff members whose achieved or potential achieved authority will stay within this scope. Conversely, if there are few staff members available, team members who are motivated to extend their operations at least partially into required areas might be chosen.

Great care should be taken in assigning the administrative functions. The keenest difficulties arise when these functions are desired by more than one or by no staff member. This aspect of the assigned authority, above all, should be carefully tailored to fit motivation and potential achieved role. If the psychiatrist, for example, is primarily interested in psychotherapy and does not have any desire for administration, he might be balanced by another team member who has the needed administrative interests and skills.

* A major theme of this paper is that a well-functioning team requires almost as much effort and foresight in its preparation and creation as is required in its performance. We have endeavored to show that merely bringing people together does not constitute a team. In view of the ever present staff scarcity, serious thought must be given to the question of how many well-functioning teams can be formed at any one time. Choosing a group with complementary degrees of motivation and achieved authority may be difficult. One might well decide that only one or even no teams may be available. In any case, the use of the proposed criteria will, we believe, bring closer the goal of efficiently functioning and relatively conflict-free psychiatric teams.

BY IRVING H. KAPLAN

Some Aspects of Group Work in a Psychiatric Setting

EARLY IN 1958 a nursing supervisor at Colorado Psychopathic Hospital approached the writer with a request for help in increasing communication and socialization among patients on what was then a closed ward for disturbed women. The following will attempt to describe what was done in meeting this request, with special emphasis on (1) what the group worker brings, (2) the role of the worker in a setting where patients stay for a relatively short time (thirty to forty days), (3) the values of group experiences to the patients, and (4) team relationships.

Hospitals designated "psychopathic" generally make diagnostic studies, provide short-term treatment, and carry on intensive educational and research programs. Because Colorado Psychopathic Hospital is a training center, the ratio of psychiatric residents to patients is much higher here than at many other psychiatric hospitals. The patient load is usually smaller than in other institutions for the mentally ill; the capacity is eighty-five, with approximately fifteen to twenty patients on wards housing the more

seriously disturbed. The hospital has a social service department of which the group workers are a part. In addition to this department, other ancillary services are the nursing, psychology, recreation, religion, volunteer, and occupational therapy departments.

Remarks about the patients will be limited to those who were on the locked ward for women. With few exceptions, the women admitted to this ward were overtly psychotic, with a diagnosis usually of schizophrenic reaction. There were also some patients diagnosed as having depressive psychoses, and on rare occasions one might find a sociopathic personality among the patient population on the ward.

WHAT THE GROUP WORKER BRINGS

Before discussing the beginning of the project, together with descriptive material, it will be useful to explore what the group worker brings with him to the psychiatric setting. Certainly he comes with a knowledge of the dynamics of individual behavior. This is rooted not only in learning derived from psychoanalytic theory, but also in our understanding of man in his relationship to society—i.e., the impact of social, economic, and political forces on man.

The group worker also comes with an understanding of the place and values of group associations in the life of the individual. More important, he brings with him knowledge of the processes that go on in

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groups. Gisela Konopka, writing of the method of social work, indicates such processes as patterns of relationship, group bond, group hostility and contagion, group support and conflict.¹ Grace Coyle formulates this a little differently in discussing the process of formation, interpersonal relations, evolution of group structure, establishment of group controls, group deliberation, group climate, and the evolution of a group value system and norms.² S. R. Slavson in an article in the *International Journal of Group Psychotherapy* gives yet another formulation.³ There is much in common in the identification of group processes by the three writers. Much is also being learned about groups through research carried on by psychologists and sociologists. The group worker brings with him this knowledge of group processes, an ability to integrate what he knows and observes, and a skill in being able to use himself consciously in relation to the people and processes studied.

He also comes with a knowledge of program media and skill in applying this knowledge. He should not only have activity skills, but must be a creative discussion leader. This skill of knowing how to elicit responses, how to stimulate interaction, how to appreciate and communicate feelings, and how to help the group focus around a problem—and then move toward a solution—is important for any group worker, regardless of setting. It is a *must* in a milieu where interaction is so limited and where problem-solving is difficult for patients.

Flowing from the group worker's experience with groups, and related to the very structure of groups, is the worker's under-

standing of the value of informal relationships and his ability to use such relationships to create an atmosphere conducive to expression. Mrs. Konopka comments on this point: "It is not accidental that the relationship between the group worker and his group is generally more informal than the individual interview. . . . The more informal relationship is inherent in the specific constellation of a worker and the group, and is consciously used by the group worker. It does mean that in work with groups, we have entered a territory where we are not alone the 'giver' but that others play an important relationship role which we must enhance, rather than to diminish."⁴

NATURE OF THE GROUP EXPERIENCE

Since the purpose of the project was to stimulate communication and socialization among patients and open up channels of communication between patients and personnel, in discussion with the senior psychiatrist and nursing staff it was agreed that the leader at these meetings be a member of the staff. It was considered unrealistic to expect patients hospitalized with severe illnesses for so short a period of time to provide leadership to achieve increased interaction and socialization among themselves.

Initially, the plan was for one of the nursing staff to act as discussion leader, with the group worker sitting in on the meeting as observer and consultant. However, because of scheduling difficulties and some question by nursing staff about taking on this responsibility, the group worker took on the leadership function. Although this was a voluntary activity, patients were urged to attend, and did so with few exceptions. The early meetings were marked by problems caused by the coming and going of the more agitated patients. This caused us to structure our seating arrangement,

⁴ Gisela Konopka, "Group Work Techniques in Joint Interviewing," *The Social Welfare Forum* (New York: Columbia University Press, 1957), p. 175.

¹ "The Method of Social Group Work" in *Concepts and Methods of Social Work* (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1958), pp. 137-139.

² *Use of Group Methods in Social Welfare Settings* (New Orleans: Tulane University, 1957), p. 12.

³ "Are There 'Group Dynamics' in Therapy Groups?" *International Journal of Group Psychotherapy*, Vol. 7, No. 2 (April 1957), p. 131.

making entrance and departure from the room more difficult, with the interesting result that there was a diminution of physical movement in and out of the circle of chairs. Additionally, as the pattern evolved for these meetings, the patients became less tense and more relaxed.

The early meetings were devoted primarily to a discussion of activities, *i.e.*, planning for a game night or decorating the ward and game rooms. The worker related to patients on this level because he felt questions might be raised by the psychiatric staff with respect to discussion of group living, patients' illness, therapeutic measures, and so on. It soon became evident that although the senior physician and head nurse were interested in activities, they were more concerned to have the worker help the patients bring out their feelings toward their living situation in the hospital. Yet despite the slow start there was some advantage in beginning interaction on a simple level before moving into other areas. Because of the high rate of turnover, the worker usually began by introducing himself, the doctor, and the nurse; then he made some remarks about why the meetings were held. On some occasions patients who had been on the ward for several weeks were asked to tell the new patients what had previously been discussed. This not only afforded an opportunity to involve patients quickly and gave the worker some insight into how they saw the meetings, but also helped to define the purposes of the meeting for new patients. For example:

I began the meeting by introducing Dr. H, Miss E (nurse), and myself. I explained to patients that we meet once weekly. I then asked if anybody could tell the new patients what these meetings were all about. Mrs. F remarked that we had talked about the radio. Could she tell everybody what we talked about? Miss R raised her hand. She said that some patients objected to all the noise the radio made. She went on to say that she personally liked to have the radio on all the

time, because she felt nervous otherwise. Miss C said that the constant noise of the radio bothered her. I said that I remembered the discussion two weeks ago and wondered whether anybody would like to tell us what decision had been made. Miss R said that the patients had agreed on certain hours when the radio could be played. I wondered how this had worked out, there was considerable shaking of heads, that it was okay so far. One patient remarked that patients remind each other when they forgot.

I continued the meeting by asking if there was anything else we had discussed. Mrs. P remarked that we had talked about the sheriff coming up to the ward and serving papers to the patients (last week there had been considerable discussion about this matter with a good deal of feeling expressed by the patients about the lack of preparation for these visits). At the mention of the word "sheriff," one new patient got up, rather agitated, and left the room. This was noted by another patient who remarked that the word "sheriff" must have frightened Mrs. T. I said that I recalled the discussion of last week and had indicated to them that staff would discuss this and see what could be done. Dr. H commented at this point as to the plans to prepare patients more adequately for the serving of these legal papers. I used this experience to remark to the patients that their expressions of concern were important, no matter how small these concerns appeared to be, and that staff was vitally interested in helping them.

At several meetings the patients had talked of regulations about smoking, feelings about seclusion, being sent to the state hospital, and so forth. The next meeting began in the same way and went on as follows:

I remarked that we had talked about several things the past few weeks, and that perhaps these were the kinds of things that new patients would like to know about when they came on the ward. I wondered as they looked back on their beginnings with the hospital what they

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felt would be helpful to them. Mrs. S, speaking in a hostile manner, asked why her jewelry had been taken away from her. Could any of the other patients help Mrs. S with this problem? Miss T remarked that sometimes patients forget where they put things, especially if they are under electro-shock therapy. Mrs. O recalled an incident that happened only recently when a patient in a fit of anger broke a lamp, adding that when this happens one might break something we really wanted. There was considerable nodding of heads as other patients recalled this incident. Several other patients talked about breakage and forgetting in trying to help Mrs. S understand the reason for some valuables being taken from her. Mrs. S relaxed somewhat, her voice having lost some of its sharpness. I remarked that perhaps Mrs. S's question was something other patients wondered about when they came on the ward. Once again there was general nodding of heads indicating that many patients had similar questions.

This experience helped staff learn some of the concerns of the patients upon arrival and afterward, and also indicated that there are times when a patient's interpretation may be more acceptable to a ward resident than what is said by the doctor or nurse.

VALUES OF THE GROUP EXPERIENCE

What were the values of the group experience, and how did they relate to the goals of communication and socialization?

1. The informal, permissive setting opened up a new channel of communication for the patient. Subject matter relating to group living situations, heretofore seldom discussed, was being brought out into the open. The patients talked of feelings about seclusion, distribution of legal papers, their responsibility in treatment, coffee before breakfast, and so on. These meetings offered another dimension to the patients' perception of what they feel is happening in the world about them and its impact on them. Furthermore, among the reactions of the

schizophrenic is that he "retreats into a world of his own making, since the real world to him is no longer tenable."⁵ These meetings have been used, at least temporarily, to pull the patient away from his little world and relate him to other people and their concerns. Perhaps such continuous satisfying experiences in human relationships may be one tool in helping the patient re-establish ego control.

At one point it was interesting to watch the effect of these meetings on a paranoid schizophrenic patient. English and Finch remark that, "The patient is constantly concerned that various individuals are working against him. . . . These people are ordinarily resentful, suspicious and irritable."⁶ This patient brought up the matter of coffee before breakfast with the hope, it appeared, that this would be turned down, thus reinforcing her feelings about people. Much to her surprise, this suggestion was taken up quite seriously by the other patients and staff. She had a considerable struggle then to continue sponsoring the idea. In discussing this matter of the paranoid patient receiving group support and praise, one psychiatrist mentioned how important this can be to a person who has constantly felt that the world has turned against him.

2. Wolberg notes that hospitalization's most insidious feature is the institutionalization that may take place, so that tendencies to regress are enormously reinforced.⁷ Institutionalization may not only tighten its grip on the patient population, but also at times envelop the staff. This is manifest in the carrying out of procedures and policies often only for the reason that this is the way it has always been done. It may well be that in many instances the old way of doing things may foster in patients precisely what

⁵ Dr. O. Spurgeon English and Stuart M. Finch, *Introduction to Psychiatry* (New York: W. W. Norton and Company, 1957), p. 332.

⁶ *Ibid.*, pp. 353-354.

⁷ Dr. Lewis R. Wolberg, *The Technique of Psychotherapy* (New York: Grune & Stratton, 1954), p. 636.

staff wants to counteract: regressive tendencies, dependency, and the general deteriorative process.

The group meetings have given patients an opportunity to challenge, question, and express feelings with regard to many things on the ward. For example:

During the course of the meeting, the question of cosmetics arose. I asked the patients how many of them came with their own cosmetics. A number raised their hands. Others indicated that they came so quickly that it was not possible for them to bring their belongings. I then asked this group what they did about using cosmetics. Mrs. P remarked that she asked the other patients. Miss N, sitting next to me, remarked that she didn't like any lending. I noticed Mrs. R and Miss S talking to each other and asked if they would like to share their thoughts. Mrs. S remarked how difficult it was constantly to run after the nurses whenever they wanted any cosmetics. The cosmetics were generally locked up and could not be obtained without asking for them. Mrs. S agreed with this, then added that there were so few extra cosmetics in the ward that she didn't feel like asking for them, because she knew that somebody else was also using the same lipstick. There was considerable discussion at this point, with suggestions made by the patients as to how this might best be handled. One patient indicated that perhaps writing to a cosmetic manufacturer might bring the ward sufficient articles for all.

As staff looked back at this meeting and others, it became apparent that they were in many instances contributing unwittingly to the infantilization of the patient and adding to her feelings of unworthiness and inadequacy. The opportunity for the expression of the concerns of the patients and the impact of many voices expressing these very real concerns have often caused a re-evaluation of ward policies and a correction supportive of the healthier parts of the patient's personality.

3. The group experience offers another

diagnostic tool in understanding the patient. It provides an on-the-spot picture of the patient in interpersonal relationships which may be used as a mirror against which to test material gathered from the patient and relatives.

4. Patients vary in their ability to use groups. Some speak up readily, some hesitantly, and others not at all. No matter how the individual patient uses the group, or the particular timing of such use, most important is the fact that there is a structure that permits patients to test reality and the new insights learned in individual psychotherapy; to receive support and encouragement; to have limits set; and so forth. It has been most interesting to observe some patients who may not have uttered a word for two weeks hesitantly begin to say something, encouraged by the atmosphere, the acceptance of other patients, or by progress made in other facets of treatment.

5. Hospitals, by the very nature of their physical structure, can be frightening to a patient—the scrubbed floors, the white uniforms and dormitories, the little space for personal belongings. Its bigness tends at times to make the hospital an austere, grim place. The physical proximity of people in a circle, the cup of coffee, talk, support, and socialization inspired by the group, all lend a warmth to hospital life which is meaningful to patients.

6. Two other aspects of the value of this group experience will bear mentioning. One is the continued communication and socialization after the meeting, as patients react to some parts of the discussion or decisions made. After the patient group had deliberated on the problem of the radio on the ward and had reached a decision with regard to handling it, their communication with respect to this matter continued long after the meeting.

For some patients, also, the beginning ability to express thoughts and concerns, together with their involvement with other people, has helped them use individual

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therapy most positively. The ward psychiatrist felt strongly that the group's encouragement of a patient to see her doctor for further help was beneficial in the total treatment of the patient.

TEAM RELATIONSHIPS

The other members of the team with whom the worker was in close contact were the senior ward physician, the senior ward nurse or her representative, and the nursing supervisor. Co-operation did not evolve smoothly or easily among all. It is important to note at the outset that any innovation in a hospital ward causes some stresses and strains to the existing fabric of relationships and the accustomed way of doing things. When the innovator happens to be a non-medical person in a medical culture, this only compounds the problems. The reader may recall that the patients were initially involved in planning activities. This meant that an already overburdened nursing personnel had to be asked for equipment and for help in staffing these activities. These demands caused considerable negative feeling toward the group worker. When clarification took place with regard to what was wanted and the group worker began to meet personnel's expectations in a competent manner, the environment became much warmer and more responsive. Then a pattern of staff relationships evolved, based on an understanding of the various roles and what was expected of each discipline at these meetings. The presence of the ward physician and nursing staff at group meetings, too, was helpful in giving patients a feeling of administrative support for these sessions.

GROUP WORKER'S ROLE

Let us now take a look at the worker's role with the patients. Primarily, skills as a discussion leader were used, undergirded by a knowledge of individual and group dynamics. One would agree with Saul Scheid-

linger, who speaks in an article of "group procedures . . . directed at those areas of the patients' ego relatively untouched by the basic pathological processes."⁸ Generally, regressive or pathological material was not dealt with.

Group procedures were utilized within the framework of therapeutic techniques practiced at Colorado Psychopathic Hospital. Because of the diagnostic categories of patients, the short-term stay at the hospital, and the fact that residents are in the beginning phases of learning, there is greater utilization of supportive therapy. This is not to imply that other psychotherapeutic techniques are not employed.

The worker attempted to use some or all of what are described in the literature as supportive techniques, which Lola G. Selby lists as follows:

1. Direct guidance and advice in practical matters.
2. Environmental modification with the provision of specific and tangible services as needed.
3. Provision of opportunity for the client or patient to discuss freely his troubling problems and his feeling about them.
4. Expression of understanding by the helper, along with assurance of interest in and concern for the patient and client.
5. Encouragement and praise implying confidence in patient's worth and abilities. . . .⁹

The group worker's role was a rather active, directive one. Quoting from Scheidlinger's article again: "The pathology of the patients, furthermore, requires the group worker to assume a directive role at many points."¹⁰ Problems raised by an individual were usually fed to the group to stimulate

⁸ Saul Scheidlinger, "Social Group Work and Group Psychotherapy," *Social Work*, Vol. 1, No. 3 (July 1956).

⁹ Lola G. Selby, "Supportive Treatment: The Development of a Concept and a Helping Method," *Social Service Review*, Vol. 30, No. 4 (December 1956), pp. 405-406.

¹⁰ Scheidlinger, *op. cit.*, p. 40.

an interactive process, with the dual goal in mind of helping the individual who raised the problem and, in so doing, assisting others with similar concerns. The stimulation of interaction, focusing of discussion, and summarizing of statements to permit choices to be made by the patients, are all indicative of the more active role played.

Another factor in the determination of the role of the group worker is the impact of the short-term stay. Because of the rapid turnover the group worker must relate himself to the needs of the particular group on the ward at any given time. This does mean that *some* goals should be realizable if patients are to have any sense of accomplishment and a feeling of *some* movement toward resolution of expressed concerns. This combination of illness plus a short stay largely determines what the worker's activity should be.

It should also be added that the brief stay on the ward can be frustrating and anxiety-provoking to the worker as he wonders who will be in the group this week and what problems will be discussed. On the other hand, the turnover helps to bring out new thoughts, new ideas, and new approaches to problems.

If at any point the impression has been given that participation of patients in discussing problems comes about easily, this notion should be quickly dissipated. There are times when the silence seems devastating and enormously frustrating. One becomes more alert to signals than previously; the nod of a head, a quizzical look, a change of posture, a quiver of the lips becomes a sign

that the patient, with some support, might mobilize herself to say something. At times, physical involvement may be resorted to when verbal communication seems to break down. Patients affected by a particular problem are asked to raise their hands, and this group is then used as a pool of participants from whom some response may be elicited. Other possible techniques have been referred to earlier. Suffice it to say that the application of the process of study, diagnosis, and treatment plan has been most helpful in determining what to do and how to do it.

One other observation regarding the group worker's role: being related to both staff and patients, the worker must be extremely careful not to overidentify with either group. This is a delicate tightrope on which to maintain balance—too many slips may lead to serious repercussions.

CONCLUSION

The group worker, because of his understanding of individual behavior, his knowledge of group processes and program, and his ability to use himself consciously in stimulating an interactive process to take place, was able to make a contribution to both patients and personnel. This contribution was measured by other requests for service, better morale, increased communication between patients and staff, and a fitting adjunctive therapy to the total treatment of the patient. Much is yet to be learned about dealing with short-term groups, the problems they pose, and methods of working with them.

BY WILMA SMYTH

Preventive Aspects of Medical Social Work Consultation in a Rural State

MUCH THOUGHT HAS gone into defining and describing the preventive aspects of the medical social work consultant's job in a public health program. More intriguing and perhaps more graphic than the official statements, however, was the comment of the ten-year-old son of an old friend whom I was visiting. When his chum asked him what I did, his mother overheard him explain, "She has a job where she worries about things before they even happen, and if she worries good enough, then maybe they don't happen." This paper will describe some of our attempts to "worry good enough" in a state where distance, weather, and lack of professional resources combine to create problems which sometimes seem as large as our famous mountains.

Montana, one of the nation's largest states with an area of over 146,000 square miles, had a population, at the last census, of less than 640,000 which is fewer than a medium-sized city such as Denver, Colorado, or Portland, Oregon. Medical resources are clustered in five widely separated "cities" of 50,000 or less population.

The medical social work consultant has been employed in the Crippled Children's Program of the State Board of Health since 1958. Consultant services are given to public health nurses and Department of Public Welfare social workers throughout

the state. Direct services are given only at the cleft palate clinics which are held monthly at three different centers throughout the state. These clinics are a part of a special cleft palate project within the State Board of Health Crippled Children's Program. This paper will describe various aspects of consultation service using the experiences at preventive intervention by the social worker at the cleft palate clinic as an example. However, the principles and practices mentioned are seen as applicable to all parts of a public health comprehensive program.

CLEFT PALATE CLINICS

Many parents come to the clinic for the first time with very little, if any, understanding of an interdisciplinary team and even less knowledge of the role of each of the members in cleft palate habilitation. While the social worker is tempted to begin by pursuing the traditional function of exploring feelings and emotional problems of the family and patient, we have found that the greatest need is to give parents some simple facts about team procedure including the job of each member of the team, the function of team discussion, and the fact that the combined recommendations will be discussed fully with the parents by one of the team members before they leave the clinic.

Our cleft palate teams utilizing the interdisciplinary process of careful team study and evaluation have won a good deal of

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recognition for the high quality of service which they provide. Many good results for patients have occurred due to the very nature of the comprehensive character of team review. Because of some well-known examples of good results, certain parents become unrealistic about expectations for their children and this in itself produces additional problems for the team. When expectations they have built up are not met, they may then be unable to accept the medical recommendations. Since we explore what the parent expects the team to be able to do for his child, which takes into account expectations not in line with reality, more intensive interpretation is given. In all instances, the parent who expects surgery to eliminate his child's problem is immediately prepared for the probable need for speech therapy, possible orthodontia at a later date and prosthesis. When a prosthesis is in order, both parents and child are prepared in advance for the fact that it will not feel comfortable at first and that the child will need speech therapy in order to learn to use it.

The child's first clinic visit offers opportunity for at least a beginning assessment of general patterns of child care and relationships within the family. Parents are encouraged to think about what the child's behavior may mean in terms of future care of the cleft. For instance, the child who at age two has encountered no consistent limits is likely at three to be such a difficult patient that he cannot use a prosthesis. With the limited time available at clinic, and the lack of opportunity for follow-up interviews, we have been unable to handle definitively the parents' underlying problems which may be responsible for the overprotection and inability to set limits for the child. We do, however, make referrals when local resources are available and the family appears able to use help.

We sometimes see serious social pathology at the clinics as in the case of Jerry's mother who confided that "all the kids drove her nuts and sometimes she was afraid she was

losing her mind because she beat the devil out of them." This disturbed mother was helped to see how the child welfare worker at the local department of public welfare could help both her and her children and she made her own application for this service.

Parents who feel disadvantaged, insecure and uncertain, who "hate to be pushed around" feel that the long waits at clinic and the time lapses between the different steps in treatment is evidence that the doctors do not care about them or their child. These parents need to feel that all members of the team are interested in them, and if necessary they are given special interpretation before their anger and resentment have begun to mount.

We have had many evidences that an important factor in keeping a child under team care for the necessary years is the parents' conviction that the doctors really care. An example is Jimmy who has a very wide cleft of the palate and for whom the team had recommended that surgery be delayed for several years. The record showed that about six months after attending a clinic Jimmy's mother had taken him to a surgeon out of the state who wanted to do an immediate closure. The program director had written to the parents, enumerating the various advantages of team care and explaining in rather technical terms why our team recommended that closure be delayed. When Jimmy appeared at our clinic a year later still unoperated, it appeared in the interview with the mother that the director's letter was a major factor in her decision to return to team care. When I asked which of the physician's points had seemed the most important to her, the mother confided, "You know, I don't remember a thing he said, and even when I read it, I couldn't understand it, with all those big words and everything, but he wrote three pages and I decided that if the head doctor cared enough about Jimmy to write a three-page letter you folks would do what's right for him."

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Often the patients and families who have the greatest need for this extra interest and attention from the team specialists are the ones whose behavior is the most provocative. To increase the understanding and acceptance by all members of the interdisciplinary team is difficult but success brings rewards not only to the children under the Crippled Children's Services Program but to countless others treated outside the clinic by all members of the team. While social work has something unique to contribute in the field of patient understanding, it is well for us to remember that we have no monopoly in this area. Years ago a crusty old surgeon said to one of our overeager young colleagues, "Young lady, it would be well for you to remember that you social workers didn't invent the idea of understanding the patient—doctors were understanding their patients long before you were born!"

In order to be helpful, our understanding must make a timely addition to the considerable understanding which most physicians already have. Too often our interpretation reaches them too late—after they have already felt and perhaps shown resentment over a parent's unco-operative behavior. To accept a casework interpretation at this point, a physician must admit, at least to himself, the incompleteness of his previous understanding and change his already emotionally charged view of the parent's behavior.

As a part of the evaluation of each case at cleft palate clinics, we discuss any parental attitudes which are likely in the future to cause missed appointments, antagonism toward professional staff, and the like. The parent's provocative behavior, when it occurs, can then be viewed by the physician as an expected problem in the habilitation of this particular child, rather than as personal antagonism directed against those who are trying to help the child.

Teamwork with other professions offers the social worker new opportunities to use

familiar social work principles and concepts in a broader program where prevention is a key word. We have made great strides in our acceptance of patients and parents, although their behavior may frustrate us. There is equally great need for us to accept our team-mates from the other professions. When one of the members of the team has an opportunity to ventilate his anger and frustration in an accepting atmosphere during team discussion, he can then be much more accepting of the attitude of parents.

Team discussions also offer an opportunity to enlarge the team members' concept of the kinds of parental functioning to be found in our society. In this state where most of the physicians normally see only private patients or children whose parental ties have already been severed by the court, they may have little concept of the "neglectful parent" as this term is used by child welfare workers. One pediatrician, who is keenly aware of the importance of emotional factors, was greatly exercised about a mother's lack of concern for the problems of her teen-age daughter who has a cleft. He proposed "shocking her into an awareness of the problems and her responsibilities." When he learned that only a few years ago the mother's neglect of the family had been so serious as to warrant a custody hearing, and that as a result of support from a child welfare worker, her parental functioning had now improved at least to the extent of providing regular meals and clean clothes for the children, he could be more supportive to this mother.

CASE CONSULTATION

While there is case consultation with physicians in connection with all aspects of the program, a considerable part of the medical social work consultant's time is spent in helping the public health nurses and department of public welfare social workers to use their professional skills in helping them with the medical social aspects of their

problems as well as prevention. The process of providing this medical social work consultation by mail involves a series of extremely difficult assessments, all of which must be made by remote control. First, in the light of the medical problem, the care which has been recommended or is likely to be recommended, and the social and emotional factors in the situation, what are likely stumbling blocks in the way of getting medical care to the child? Second, what resources are available locally to help this family in the prevention or resolution of these problems? Third, what supplementary information or guidance will these resources need to help them in helping the family? Fourth, can this information or guidance be given to them within the time limits imposed by the situation and if so, how? We carry on a never ending search for better ways of anticipating trouble spots in case situations and giving these people the kinds of information that will enable them to keep little problems from growing into big ones.

Several years ago a little girl from one of our smallest countries was scheduled to go to Denver for heart surgery. The family wrote to Crippled Children's Services explaining that they could not keep the appointment because they had no money to make the trip. Crippled Children's Services enlisted the help of the local department of public welfare social worker who aroused the interest of several community groups. There ensued a series of bake sales, benefit dances, and similar activities as a result of which the family received enough money for the trip. However, Aunt Minnie came to visit just then and, although they never had liked her very well, they said they just could not go off to Denver and leave her. The whole community, which had worked so hard to provide the trip, was furious at the family (and at Crippled Children's Services for having initiated this project!). It was some months later that the mother confided to one of our staff at crippled children's clinic that when the

time came she just could not face surgery for her daughter.

Recently a similar situation arose, only this time in our letter of referral to the department of public welfare social worker asking help with the family's traveling expenses, we also mentioned the possibility of an underlying fear of surgery in addition to the very real financial problems. We suggested that she encourage the parents to talk once more with their physician about the risks of having this operation, and the risks of not having it. Once more a community went all out to raise funds, only this time the family's doubts about surgery were resolved, they made the trip, and a child has a chance for a longer and happier life.

Perhaps the most difficult of our unsolved problems is deciding when and how to enlist the help of local social work and nursing staff in solving medical care problems which stem from complicated emotional factors. We have tended to be optimistic in our expectations of what these people can achieve, although we recognize that there is real danger of damage to patient and family if emotional problems are dealt with unskillfully. Unorthodox approaches of some of these people have resulted in some anxious moments for us, but thus far we know of no instances in which harm to patient or family has occurred. Because of our geographic problems, we have struggled with the necessity to send written material to unknown sources, while seeking to safeguard the confidentiality of the material.

PARTICIPATION IN POLICY FORMATION

Many social workers tend to be problem oriented and case oriented probably because of long experience of working in hospital settings with the one-to-one emphasis. For those who work in public health, there is a tremendous challenge to broaden their scope to include the many social problems related to medical care. This means that we cannot limit our focus

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to traditional social casework, but must think imaginatively about all the ways in which social work knowledge can be used in the public health department to accomplish the goal of a broad public health program which includes concern for medical social problems. For instance, participation in policy formation and working out of procedural details, which may seem tedious for the caseworker new to the field of public health, offers major opportunities for case-finding, and for early involvement of parents. Take, for example, our keen awareness of the importance of parent participation in all aspects of planning care for a child. How convenient it would be if we could just state this principle and be certain that the participation of parents would then come to pass! Although none of the professions will want to limit the participation of parents, the medical care conveyor belt has a way of taking over so that appointments are given, diagnostic tests ordered, and treatment authorized with the parent having little idea of why these things are being done, what benefit his child can expect from them. It may be only when a parent is unable to participate in planning at a critical point in the care of his child that anyone suspects the doubts and resistances that have been mounting over a period of time.

We are trying to build into our "routine" procedures for authorization of care some ways of testing for the parents' understanding and acceptance of the care which is planned. It is not difficult to convince one's co-workers from other professions of the desirability of such a plan, but we then come to the "what" and "how" of implementing it. This means bringing social work knowledge to bear in the important area of developing manuals, drafting policy statements, outlining needed procedures and similar activities.

STAFF DEVELOPMENT

Another aspect of the medical social work consultant's job which is preventive in the

broadest sense of the word is that of staff development. In reviewing a series of cases in which medical social problems are interfering with medical care, we found that in the majority of them either a public health nurse or a social worker had seen the beginnings of the problems or social and emotional conditions likely to lead to such problems. It is important then that these people should be helped to recognize and to deal helpfully with such situations during their early phases. However, when a medical social worker gives this kind of help to members of another profession, or of another specialty within her own profession, she must clarify her goals, first for herself, and then for those whom she would help.

First, she must recognize that these people have their own skills, their own primary functions, and their own specific goals, although they share with the medical social work consultant the broad goal of helping children and their families. The problem then is to help these people in the way that they want to be helped, to do their own jobs in such a way that some medical social problems may be prevented or minimized. The specialized understanding and techniques of medical social work are shared with other professions in relation to *their* problems and in ways which *their* supervisors see as fitting into an over-all staff development plan. Staff, supervisor, and consultant all participate in choosing the subject or problem to be discussed. The consultant takes the lead in this, and all members of the group share in introducing pertinent theory. Resulting from this there is testing, trying, accepting, and rejecting, first in discussion and then in the staff's professional practice.

Staff development of this type takes considerable time of the consultant and the one medical social work consultant in a large state may wonder whether she can afford this much time. Although we have developed no satisfactory way of evaluating the results of this activity in terms of benefit

to our cases, we are convinced that it is considerable. While we may not yet be sure that we have time to do this, we are sure that we have not time *not* to do it.

SUMMARY

The public health setting provides a tremendous opportunity and challenge to the medical social work consultant who has been accustomed to focusing on individual cases and problems and of using basic concepts and techniques applied to public health programs that focus on prevention. Direct services and case consultation offer a variety of opportunities for solving problems and furthering prevention. Staff development and participation in working out policy and procedure offer additional opportunities to use knowledge as it applies to broader programs although we must learn to think in new ways in order to take advantage of these opportunities.

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BY JANE WILLE

Goals and Values in Education: Their Implications for Social Work Education

MEMBERS OF VARIOUS professional groups in their day-to-day encounters have some awareness of communication difficulties that exist in part because of differences in their values and goals. Most professional groups have acquired values and goals characteristic both of our democratic society and of the purposes of the institution and service they represent. Social workers, engrossed in studying and establishing the values and goals of their own profession, have not always been aware of similar efforts in other professions. Through lack of knowledge, it may seem that there is wide variance between the values and goals of education and those of social work. If these two professions are to work together effectively, it is important that they develop not just opinions but an informed understanding of each other and an appreciation of the problems they both face as they attempt to establish values and goals in an ever changing society.

In much of the educational literature no clear distinction is made between values and goals. For clarification of this relationship I have found a statement by Ashley Montagu helpful, which defines values as:

... the maintenance of a set toward the attainment of a goal. The person learns to want many goals. When these goals are remote and strived for, value obtains. When the person blindly gropes for some undefined goal in a random manner, value does not obtain. Some definitely known goal must be held in view. This last statement takes its existential form from the fact that a goal is being contemplated or approached, rather than actual achievement of the goals.¹

Perhaps a representative over-all statement best sums up the many and varied goals in education. In the Lake Forest conference on the administration of school social work programs in 1958, Forrest E. Conner opened his talk with this statement:

Education today is a dynamic social process. Its responsibility to our society is to protect, strengthen, and extend democracy and to preserve, rebuild, and fortify human and natural resources. Our schools must provide a program to meet the educational needs of all children. Wherever necessary, they should provide supplementary help for children so that they may use their school experiences to the best of their abilities.

In our nation, the primary purposes of the school are to guide each child, according to his ability, in the pursuit of knowledge and truth, in the development of useful skills, and in the ability to think clearly and independently; to prepare him in the ways of democracy;

JANE WILLE, M.S.S.A., was assistant to the director, Illinois Office of Public Instruction, Division of Exceptional Children, School Social Work, when she gave this paper at the Conference on the Contribution of School Social Work to Social Work Education, August 1959, Highland Park, Illinois. She is presently associate professor, School of Social Work, University of Illinois. The article was selected for this issue by the School Social Work Section.

¹ M. F. Ashley Montagu, *The Direction of Human Development* (New York: Harper and Bros., 1955), Appendix A, p. 345.

to help him develop self-respect, self-discipline, and moral strength along with mutual respect for others; to help him to prepare to earn a living and to live with reasonable dignity and happiness. In short, education's responsibility to society is to guide and encourage each child and adult to work for the full development of his intellectual, physical, spiritual, and social endowments. No education is adequate which neglects any of these needs. The ultimate strength of our country depends on the moral strength, economic competence, and social responsibility of the individual citizen.²

Any examination of the values and goals of education must take into consideration the fact that these values and goals are not static and will be changing with a society. The need for examination of educational goals is particularly pertinent at this time if we are to heed the criticisms of Margaret Mead and others that "the educational system is suffering from obsolescence."³ Quincy Wright, professor of international law at the University of Chicago, observes, "Today skills, knowledge and value systems all have a high rate of obsolescence. As a consequence the continued utility of the ideas and principles learned in college becomes problematical. Emphasis must be increasingly upon methods and process for discovering or inventing ideas, principles, and standards rather than upon the ideas, principles, and standards themselves."⁴ In any study of education as reflected in such statements it is important to examine the total society and its needs at the particular time. This helps to make intelligible the pressures put on education for change. For

this reason it is important to examine some of the current criticisms of education and suggestions for changes in emphasis.

CURRENT CRITICISMS OF EDUCATION

One of the recent points of emphasis in current studies of education is the importance of giving more attention to the achievement of excellence. The Rockefeller Report on Education describes this need as follows: "A nation only achieves the kind of greatness it seeks and understands. Only if we value intellectual excellence shall we have it." This report does not stress attainment of excellence as an exclusive concern without relation to other goals. Education is described as "not just . . . a mechanical process for communication to the young of certain skills and information. It springs from deeply rooted convictions. And if it is to have vitality both teachers and students must be infused with the values shaping the system. When ability is brought to life by aspiration, there is the further question of the ends to which these gifts are applied. We do not wish to nurture the man of great talent and evil purpose. Individuals should be free and morally responsible."⁵

Another criticism of education today is the concern of many that American youth today tends to seek security and conformity in the organization and structure of our industrial society. To inspire a reactivation of creativity and productive thinking, business concerns have resorted to "brain-storming" techniques and other devices to free intellectual powers that seem to lie dormant. As we examine this criticism, it seems important to determine what weakness there may be in the educational goals and values to which our schools have been committed. The statements made by leading educators are sound and hold much

² "Education Today," in John Nebo, ed., *Administration of School Social Work* (New York: National Association of Social Workers, 1960), p. 13.

³ Margaret Mead, "Why Is Education Obsolete?" *The Education Digest*, Vol. 24, No. 6 (February 1959), pp. 1-5.

⁴ Quincy Wright, Appendix 3, Comment I in Lyman Bryson, Louis Finkelstein, and R. M. MacIver, eds., *Goals for American Education: A Symposium* (New York and London: Harper and Bros., 1950), p. 502.

⁵ Rockefeller Bros. Fund, "Motivation and Values," in *The Pursuit of Excellence: Education and the Future of America*, Special Studies Project Report V of the America at Mid-Century Series (Garden City, N. Y.: Doubleday & Co., 1958).

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promise. Perhaps values other than those articulated in statements of educational purpose have been characteristic of our society and have to some extent permeated the school system. We might speculate that the overemphasis on conformity of many young people is related to conditions in our economic and social life and so becomes subtly reflected in our schools. Critics are wondering whether the schools have put more value on *what* to think than on helping children learn *how* to think creatively.

Another important area under question is that of the school's responsibility in the area of moral and spiritual values. There has been criticism of the schools for lack of emphasis in this sphere. The Educational Policies Commission of the National Education Association has examined this criticism and considered the role of the school in the teaching of moral and spiritual values. The report of their findings and recommendations notes that "the development of moral and spiritual values is basic to all other educational objectives. Education uninspired by moral and spiritual values is directionless. Values unapplied in human behavior are empty."⁶ Such statements convey the position statement of this important educational group, with the added view that "the basic moral and spiritual value in American life is the supreme importance of the individual personality."

In respect to religious instruction, the following statement is made: "There can be no doubt that the American democracy is grounded on religious tradition. While religion may not be the only source for democratic moral and spiritual values, it is surely one of the important sources. For this objective reason, if for no other, an attitude of respect toward religion should prevail in the public schools. The character of public education does not require the

public schools to dismiss religious beliefs as trivial." The commission stated that "the public schools can and should teach about religion without advocating or teaching any religious creed."⁷

The list of critics and suggested emphases for the public schools could be endless. The above illustrations should indicate that public schools, operating in a democracy, have no easy task in defining and holding to values and goals. It is important that social workers assume responsibility for understanding the problems of educators and contribute their efforts toward helping to establish valid goals for the public schools.

PUBLIC SCHOOL NEEDS PARTNERS

It is clearly recognized by educators that the schools cannot pursue their goals without relation to other social forces in society. The Educational Policies Commission pointed this out in the following statement:

If an exchange of ideas, strong bonds of mutual interest, and close cooperation on moral and spiritual values are to be developed in the community, the public schools must take the lead. The activities of the homes, the churches, and all of the various agencies interested in social well being must be mobilized. Without assuming administrative authority beyond its proper scope, the public schools should endeavor to unite the forces of the community for constructive development of childhood and youth. . . . The public schools will continue to be indispensable in the total process of developing moral and spiritual values. They can and should increase their effectiveness in this respect. Their role is one that no other institution can play as well or at all. But the public school cannot act every part in the complex drama of personality formation. Any hope on the part of the public school to do the whole job unaided is doomed to disappointment. Any attempt on the part of the teaching profession to assume such a staggering responsibility would be certain to end in

⁶ National Education Association and American Association of School Administrators, Educational Policies Commission, *Moral and Spiritual Values in the Public Schools* (Washington, D.C.: NEA, 1951).

⁷ *Ibid.*, p. 73.

frustration. The public school needs partners.⁸

The profession of social work is serving as one of the partners of education in the task of uniting the forces of the community for the constructive development of childhood and youth. If social work is to be an effective partner, it is necessary to examine its values and goals as they relate to the purposes and goals of education. Essential social work values have been defined by Werner W. Boehm, who served as director and co-ordinator of the Curriculum Study of the Council on Social Work Education, as:

1. Each person has the right to self-fulfillment, deriving from his inherent capacity and thrust toward that goal.

2. Each person has the obligation, as a member of society, to seek ways of self-fulfillment that contribute to the common good.

3. Society has the obligation to facilitate the self-fulfillment of the individual and the right to enrichment through the contribution of its individual members.

4. Each person requires for the harmonious development of his powers socially provided and socially safeguarded opportunities for satisfying his basic needs in the physical, psychological, economic, cultural, aesthetic, and spiritual realms.

5. As society becomes more complex and interdependent, increasingly specialized social organization is required to facilitate the individual's efforts at self-realization. . . .

6. To permit both self-realization and contribution to society by the individual, social organization must make available socially sanctioned and socially provided devices for needs satisfaction as wide in range, variety, and quality as the general welfare allows.

. . . The goal of social work is the enhancement of social functioning wherever the need for such enhancement is either socially or individually perceived.⁹

⁸ *Ibid.*, p. 120.

⁹ Werner W. Boehm, "The Nature of Social Work," *Social Work*, Vol. 3, No. 2 (April 1958), pp. 12-13.

This goal, as applied to social work in the schools, focuses on helping the child to perform his role as a student. It takes cognizance of the school social worker's concern with the child's potential capacity to achieve a satisfactory student role. It also includes the social worker's responsibility to assist the school in making an effective contribution to the individual child's role performance, through the provision of suitable educational resources and opportunities.

DIFFERENCES BETWEEN TEACHERS AND SOCIAL WORKERS

As is evident from the review of statements of educators and social workers, the broad basic goals and values of both education and social work are similar. Some dissimilarity may be found in more specific or secondary goals and values. Schools value achievement, excellence, and co-operative work—and, to some extent, conformity. Teachers also value neatness and cleanliness. Social workers value the process of growth, the indications of some change, however infinitesimal. Social workers also value expressions of differences. They tend to accept and value a wider range of diversity in behavior, appearance, viewpoint, and beliefs than is characteristic of other groups, including teachers. Often they place less emphasis on neatness and cleanliness, although individual social workers, like individual teachers, vary considerably in the importance they attach to these values.

There is difference, also, in the method of achieving goals and values. Goals in education are considered possible of attainment through an educative process, one of drawing out the potential of the learner through methods based upon knowledge of child development and the psychology of learning. These teaching methods rely on motivating the child, who because of his natural curiosity is eager to learn of the world about him. However, teaching methods are related to the individual child

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as a member of the group. The teacher is able to individualize the school program to some extent, but must always focus on the achievement of a large number of children. The teacher is conscious that her class is expected to attain a certain level of achievement and that she, as a teacher, is expected to help the child acquire specific knowledge, skills, and attitudes by the end of a semester or a school year.

The social worker in the school does not have responsibility for specific achievement of an individual child or of a group. His help is focused on the individual child as he works, through a relationship with this child, to enable him to take some responsibility for his participation in the student role. There are no pressures of time; there are no norms established. The social worker, who has knowledge of the values of the child's family, understands the conflicts which the child experiences because of differing teacher values. Such values as cleanliness, orderliness, and no fighting or swearing may represent an entirely different value system for the child. The social worker views the child's difficulty in accepting and adhering to such values in the context of his family and neighborhood pattern. His goal is to help the child attain an appreciation of school values based on more than superficial conformity.

INSTITUTIONAL AND PERSONAL INFLUENCES

In any consideration of goals and values, we recognize that they are implemented by institutions and people within these institutions. The administrative head, the superintendent, or principal in a particular school sets the tone for the school in many respects. The administrator brings with him to the school his own philosophy, shaped by his family, his educational experience, his past associations with school and community people who have influenced him. If he values democratic participation in formulation of policy, the total school

is affected by his values and methods of work. The value emphases and goals of the members of the school board in turn affect the goals of the school. These values are reflected in decisions relating to adequacy of salary for teachers, expansion of physical plant, kind and extension of educational services such as provision for handicapped children, gifted children, and others who require special facilities. The representation of the various professional, business, and labor groups on the school board bring different value emphases, and shape priorities in educational planning. To the extent that the school board membership is representative of diverse nationality, religious, economic, and cultural groups in the community, the value systems and goals which the various segments of the community endorse find expression in decisions made by the board.

In a particular school building, the principal is the key person. His leadership is responsible for the school climate that can encourage creativity and promote unified effort on the part of teachers and special personnel to achieve co-operatively determined goals. The principal's values—both his professional philosophy and his personal attitudes and beliefs—are conveyed to teachers and also to children. If the principal is authoritarian in his direction of the school, the value system of the total school is influenced by this value pattern.

Teachers, although influenced by administrative direction, also transmit many of their own value patterns to children, both through direct teaching and, indirectly, through attitudes which are readily apparent to children.

Social workers, who in their professional education have acquired more conscious awareness of their values, tend to examine them somewhat objectively. They are aware that values such as the worth of the individual and the interdependence of man are fundamental to their professional practice. Most social workers have modified some of their former prejudices sufficiently to ac-

quire an acceptance of many differences in people. Yet they are often not aware of the extent to which their own cultural background is still influencing secondary values. For instance, the social worker in school may attach considerable importance to achievement in specific academic areas such as reading, even though, for a particular child, mastery of this subject may exceed his capabilities.

In the above material we have tried to see how the values and goals of the school are affected by the principals, teachers, and school social workers. In this process of transmission of the value system of the school, even though there is considerable harmony in the values of the school faculty, the children are also bringing to the school the values of their own homes and neighborhoods. At times there is marked divergence between the values of a child's family and neighborhood and those of the school. The value of an education itself is not accepted fully by many parents. Some groups accept an education for boys, but less education for girls. Some parents do not value the physical care for children which the school considers desirable or the kind of food the teacher considers essential or healthful.

Even when there is fairly common agreement about values and goals, it is important to recognize that in the implementation of secondary goals and values, incompatibility may exist. For example, there are times when the exercise of the democratic principle of common consent may deny rights to some individuals.

HOW SOCIAL WORK CAN HELP

Social workers in the schools are in a position to help the school in the attainment of goals and in maintaining values. The school social worker makes a contribution through interpreting the values and goals of the school to parents. He is also in the unique position of being an interpreter of the values and goals of the child's home to

the school. In instances of individual psychological problems, often responsible for the temporary rejection by a boy or girl of the values of his home or the school, the school social worker also serves as an interpreter who can help teacher and parent to understand and deal with this phase of the child's development. Such problems are particularly evident in the adolescent years, when boys sometimes devalue the stress which mothers and teachers place on achievement of high grades at school. With the current emphasis on identifying the talented youth in our society and helping to develop his talents through provision of superior educational opportunities, the values of the young people themselves may be altered in respect to the status accorded the student of serious purpose, "the brain," who until recently has borne the brunt of many adolescent gibes.

Educators and social workers both recognize that changing emphases in our society will affect value systems of educators, children, and parents. Educators and social workers are both aware that the present emphasis on the gifted should not alter the fundamental goal of "helping each child to become as good and capable in every way as native endowment permits," defined in the final report of the White House Conference on Education. Dr. Lawrence Derthick, U.S. Commissioner of Education, at the Lake Forest Conference commented that "we still have a mighty long way to go in America to extend to all children the kind and quality of educational opportunities that these aims call for."

If social work, as an influential force in our society, is to help achieve this fundamental goal it is essential that social workers relate to the basic institution of education in a significant way. They must gain knowledge of the broad aspects of education, of its philosophy and developments in the context of changing needs in American society. Education has responded to changing conditions in different periods. When the primary need of our nation was

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for the development of a literate people, it moved in this direction. In the current century, educators are again advocating changes in response to demands of various segments of our society and rapidly changing developments that affect it. Concern for mental training, for life adjustment, for citizenship, for meeting vocational needs, for special provisions for children with handicapping conditions, all have been recognized and have made an impact on educational offerings. Educators have also attempted to "do anything which will bring a child up to the starting line of adult life as even with his contemporaries as native differences in ability permit."¹⁰ Today the demands of a technological society are requiring a new look at curriculum, and the emphasis on development of talented youth is growing. In the context of present demands, social workers have a contribution to make by supporting educators who are stressing the human relations aspect of education. Social workers in the schools also have a contribution to make in helping with some of the talented youth who are unable to utilize their potential because of emotional problems or the influence of value patterns of their peer group, which prevent their engaging in serious educational endeavor.

Educators have often taken responsibility

for becoming informed about social welfare needs and methods of meeting them. They have participated in and sometimes given leadership to the establishment of social agencies, such as family welfare agencies and mental health clinics. They have served on boards of social agencies and are becoming increasingly familiar with the purposes and services of specific agencies. Social workers have often turned to educators for support in matters related to child welfare. They have not always assumed the same kind of responsibility for becoming informed and offering leadership in relation to school needs. They have not always shown sufficient interest in such problems as obtaining adequate school facilities and adequate salaries for teachers, or for supporting bond issues designed to improve the schools. Social workers have not participated in education conferences as effectively as one might wish, contributing out of their knowledge material helpful to educators in considering values and goals in education and methods of implementing them in the schools.

Social work education, which has concern for the total welfare of people, has much to offer in its program that can broaden the sights of students. They may thus become able to assume informed and capable leadership in working with educators, and help to co-ordinate total services for people so that the values and goals of both education and social work are more effectively realized.

¹⁰ Summary statement of the Report of the Committee for the White House Conference on Education, A Report to the President (April 1956), p. 5.

BY LOIS PETTIT

Some Observations on the Negro Culture in the United States

THE PLIGHT of the Negro in the United States received world-wide attention on May 17, 1954, when the U.S. Supreme Court declared an end to the practice of segregation in the public schools. Social workers, long cognizant of the wide variety of inequities borne by the Negro people, welcomed this decision.

Problems faced by Negroes are well known to social workers, whose professional functions are said to include the following: "Restoration of impaired capacity, provision of individual and social resources, and prevention of social dysfunction. . . . The focus on social relationships . . . is suggested as the *distinguishing characteristic* of the social work profession."¹ Since the great majority of Negroes formerly lived in southern rural sections where social work rarely if ever touched their daily lives, the concern of social workers about the problems of Negroes was at first largely academic. "Negroes were initially brought to the Southern states and had remained there. After the importation of slaves had ceased, the immigration of Negroes was almost negligible. Changes in distribution were primarily consequences of internal movements."² However, the population picture of the 1800's, when over 90 percent of the Negro population was living in the South, changed very drastically, and the exodus of Negroes constituted a one-way migration directed from the South

to all other regions of the country. The pre-Civil War distribution of Negro population shifted from 92 percent in the South, 4 percent in the Northeast, not quite 4 percent in the North Central states, and none in the West to a distribution in 1950—a century later—of only 68 percent in the South, over 13 percent in the Northeast, nearly 15 percent in the North Central area, and almost 4 percent in the West. Whereas by 1900 less than 3 percent had shifted away from the South, by 1930 another 11 percent had gone, while the next 11 percent or so required only 20 years to move away.³

The most characteristic feature of Negro migration has been his conversion to city dwelling. "During the last half-century, when the proportion of the population living in urban areas increased from 40 percent to 64 percent, the proportion of Negroes living in urban areas increased even more rapidly. . . . Outside the South, nearly all the Negro population is urban."⁴ The fact that the Negro population has become increasingly urban makes available to him more social work services. The extent of Negro population by the 1950 census in the largest urbanized areas of the United States may be seen from the accompanying table.

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¹ Werner W. Boehm, *Objectives of the Social Work Curriculum of the Future* (New York: Council on Social Work Education, 1959), p. 54.

² Conrad Taeuber and Irene B. Taeuber, *The Changing Population of the United States* (New York: John Wiley and Sons, 1958), pp. 109-110.

³ From Table 17, *ibid.*, p. 72.

⁴ *Ibid.*, p. 124.

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NEGRO POPULATION AS PERCENT OF TOTAL POPULATION FOR LARGEST URBANIZED AREAS IN THE UNITED STATES: 1950

(Urbanized Areas by Rank Order According to Percent of Negro Population)

Rank	Urbanized Areas	Total Population	Negro Population	
			Total Negro Population	Percent
	Total, all areas	40,444,956	3,897,027	
1	Washington, D.C.	1,287,333	307,224	23.9
2	Baltimore	1,161,852	239,267	20.6
3	Philadelphia	2,922,470	433,199	14.8
4	St. Louis	1,400,058	205,216	14.6
5	Detroit	2,659,398	346,174	13.0
6	Chicago	4,920,816	572,180	11.6
7	Cincinnati	813,292	93,111	11.4
8	Cleveland	1,383,599	150,163	10.9
9	New York-Northeastern New Jersey	12,296,117	990,143	8.0
10	Pittsburgh	1,532,953	117,406	7.6
11	San Francisco-Oakland	2,022,078	141,865	7.0
12	Los Angeles	3,996,946	215,697	5.4
13	Milwaukee	829,495	21,893	2.6
14	Boston	2,233,448	50,928	2.3
15	Minneapolis-St. Paul	985,101	12,561	1.3

Source: U.S. Bureau of the Census, 1950 Census of Population.

ATTITUDES OF SOCIAL WORKERS

Attitudes of individual social workers in recent years have served as a deterrent to increased cultural knowledge regarding the Negro group. A number of them, seeking to make allowance for the effects of discriminatory practices, have attempted to obliterate any differences between Negroes and whites. Because of a belief that to identify a Negro as Negro would imply discrimination some unsound practices have taken place. For instance, in one agency the workers were no longer indicating the race of the client on the face sheet of the case record. In one large city, the designation of race was dropped from the school census; later it was realized that valuable information regarding population movement had been permanently lost.

Sometimes the denial of specific Negro characteristics is based upon the social worker's belief that the same factors could be found among whites. Such an attitude

overlooks the fact that although similarities may exist among individuals of several groups this does not negate the more basic fact of significant biological or cultural differences between those groups. Another attitude common among social workers is what Frazier terms "tender condescension." He claims that this is shown especially in "the exaggerated evaluation of the Negro's intellectual and artistic achievements. In fact, it is difficult to obtain an objective appraisal of the work of Negro students and artists."⁵ It may be that these attitudes of social workers seemed to help them adopt an objective viewpoint in professional undertakings,⁶ but it is time for the social work profession to become more knowledgeable about real and existing differences.

⁵ E. Franklin Frazier, "Human, All Too Human: The Negro's Vested Interest in Segregation," *Survey Graphic*, Vol. 36, No. 1 (January 1947), p. 75.

⁶ See Inabel Burns Lindsay, "Race as a Factor in the Caseworker's Role," *Social Casework*, Vol. 27, No. 3 (March 1947), pp. 101-107.

REAL DIFFERENCES

The major distinguishing physical feature of the Negro is skin color, although other characteristics such as facial features and hair texture might also be included. However, the social definition determining whether a person is classified as Negro exists in this country on a basis very different from that of physical appearance alone. It does not matter whether the percentage of Negro blood is one-eighth, one-sixteenth, or too minute to be discernible; if a person has any known Negro ancestry he is considered to be a Negro.⁷ This social definition is so firmly established in the United States that even the census figures are obtained upon this basis. In the Latin American countries, on the contrary, a person may possess many Negroid features and have known Negro ancestry but he may still be regarded as belonging to the white group. As a result of the prevalence of the social definition prevailing in the United States, persons of Negro ancestry who want to be considered white are forced to use the utmost secrecy in crossing the color line.⁸ It has been estimated that 2,000 to 30,000 such persons cross the color line annually. This practice is termed "passing."

Because of his identifiable physical characteristics and the rigid social definition, the Negro in the United States has been assigned to an unalterable status. Allowing for class differences that have evolved, as well as the complex and changing nature of the position of the Negro group, nevertheless some cultural factors can be elucidated.

The first Negroes to set foot in the United States were a group of twenty purchased from a Dutch man-of-war in 1619 by the Virginia settlers. At that time there was no

provision in English law for slavery, but the treatment of Negro servants was different from that of white servants. Gradually Virginia incorporated into its laws various references to the Negro as a slave, until the slave status was fixed by law in 1670.⁹ In the South the system of Negro slavery developed on the plantations. In the North the picture was quite different, northern slaves being ordinarily domestics and personal servants. During and after the Revolutionary War a number of the northern states put an end to slavery through legislation and other such means, including manumission (formal liberation of a slave); thus a growing number of Negroes achieved free status.

THE MATRIARCHAL PATTERN

Two and a half centuries of slavery in the United States changed the Negro family structure. The matriarchal system of the Negro family is well known. Under slavery, since the father was more subject to the instability and vicissitudes of the system, the mother was the most constant and dependable member of the family. The Reconstruction Period following the Emancipation Proclamation of 1863 added to the social disorganization of the Negro family unit when refugees swarmed to the army camps and cities in search of employment and housing.

Even today, particularly in lower-class families, the position of the mother is very strong. Her relationship to the children assumes more significance than does that of the father with his more ephemeral presence. She is the mainstay psychologically and economically. Analysis of the census figures reflect the more stable presence of the mother in the family. The Taeubers give the following summary:

The distinguishing characteristics of the marital status of the Negroes lay more in

⁷ See Brewton Berry, *Race and Ethnic Relations* (rev. ed.; Boston: Houghton Mifflin Company, 1958), pp. 30-31.

⁸ A novel vividly portraying this social phenomenon is *I Passed for White* by Reba Lee as told to Mary Hastings Bradley (New York: Longmans, Green and Co., 1955).

⁹ See E. Franklin Frazier, *The Negro in the United States* (rev. ed.; New York: The Macmillan Company, 1957), pp. 22-26.

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the dissolution and re-formation of marriages and the prevalence of informal marriages than in such formal facts as age at marriage or prevalence of marriage. Marital instability and high mortality reinforced each other in reducing the proportion of Negro women married and living with husbands and increasing the proportion of the widowed. In 1910 and 1940 the percentages of women who were or had been married was higher for Negroes than for native whites. In both years, however, relatively low percentages of Negro women were living in first marriages with husbands present, while relatively high percentages reported absent husbands. The proportions of widowed and divorced women were also high among the Negroes.¹⁰

The manifestations of the Oedipal conflict in the Negro family in which the position of the mother is dominant differ from those found in the patriarchal family because the girl as well as the boy is strongly attached to the mother. Even when the children are grown, they consider that their mother has first claim upon their loyalties and earnings and they take pride in coming to her rescue in emergencies. When loyalty to the mother takes precedence over the son's or daughter's newly established family, marital discord can result. As one man expressed it to his caseworker, "I can always get another wife but a man has only one mother." Such an attitude might be considered a neurotic symptom in a white male client, but in a Negro client the cultural factor may be cogent.

The dominant woman in the Negro family is frequently the grandmother, with the mother operating in a sort of second-in-command ego-ideal of the grandmother. The grandmother, regardless of her physical vigor, occupies such a strong position that she often determines the moral, economic, and emotional structure of the family. She has tremendous power and sets the emotional tone of the household in supervising

the adolescent grandchildren, determining the disposition of children born out of wedlock, and so on.

PROBLEM OF ADOPTIONS

Do social workers take into account the peculiar distinguishing characteristics of the Negro family, particularly in the lower class? They do not appear to do so in adoption work, which may explain why the problem of Negro adoptions has become such a pressing one. Different methods may be required to keep pace with the need. The usual adoption process places upon the applicants much of the responsibility for initiating and carrying through each step of the application. The purposefulness, the energy and forthright attitude, and the unity of husband and wife are tested by this process. These diagnostic procedures work well in the case of white applicants but not in the case of Negro applicants, who are all too few in number anyway.

Essentially the difference between the Negro and white applicant is that the latter carries some reasonable expectation of acceptance of his application, while the Negro applicant consciously or unconsciously expects to be rejected. In general, a Negro's experience with the law has been unfortunate, and he will protect himself from running the risk of rejection unless he has some guarantee of a good chance of acceptance. When the usual adoption procedures, intended to measure motivation as well as to facilitate the agency's work, are applied, the average Negro couple is turned down.

What then, instead? First of all, many of the usual criteria established in adoption practice may need to be reassessed in the light of cultural differences of the Negro group. Even the expressed interest of the husband may be different, for it is common for the Negro husband to want to wait in the automobile while his wife makes arrangements with the social worker in the agency office. The agency may need to reach out through informal contacts to locate and encourage these childless couples.

¹⁰ Taeuber and Taeuber, *op. cit.*, p. 157.

The social worker can be prepared (1) to extend warm friendliness to guarantee acceptance of them as individuals; (2) to arrive at an early diagnostic decision regarding them as applicants; and (3) to follow up the decision of acceptance by aiding them in every way possible to establish their eligibility for an adoptive child.

Other agencies also, to assure better service to the Negro group, may need to review their reception, intake, and continued service procedures and philosophy. Differences of locality as well as social class can be taken into account.

ATTITUDES OF NEGROES

The Negro's concern about possible rejection for reasons solely of race is always with him whether he lives in the North or South. He may be discriminated against in housing, in employment, in health services, in restaurants, and in theaters. Consequently he has armed himself, and his armor may serve to make him a hypersensitive and suspicious person. For example, a Negro social worker entered a drugstore for a light lunch and was ushered to a rear booth. She immediately protested, whereupon the amazed clerk explained that there was a fine breeze in the rear of the store even on that sweltering day. This trifling incident serves to illustrate the constant expectation of rejection which the Negro may incorporate into his attitudes and ways of thinking. His bitterness may emerge even when he is receiving commendation; some white friends of a Negro educator in admiring the latter's new home happened to mention favorably the luxuriant growth of grass on the lawn. The educator's response was that white people always say that Negroes cannot grow grass because of the bare yards of the Negro hovels in the South.

Other manifestations of the Negro's reaction to his depressed status are manifold. His self-image is very much affected by the extent to which he has Negroid characteristics. Some Negro mothers are outspoken in their preference for the lighter-skinned

child with "good" hair (not frizzy or woolly).¹¹ The Negro in his desire for emancipation often wants to leave behind him activities associated with southern rural living. Disdain may be expressed for everyday tasks of household management on the grounds of not wanting to be a "kitchen girl" or "yard boy." Sometimes habits of indolence are embraced in what Rose terms "traditions of inefficiency."¹²

Relations between Negroes and whites have been difficult to maintain because of the heritage of stress and strain. The specter of the stereotype is ever present. When Negroes are friendly toward whites, they risk censure from other Negroes. One such instance occurred when a social group worker had a chance encounter outdoors with the mother of one of her young clients. The group worker, who happened to be white, considered that she had established a good relationship with the Negro mother after several home visits. Much to the group worker's surprise the mother, who was standing on the sidewalk with some of her friends in her own racial group, was not at all cordial. It was only later that the worker realized that the mother, in the presence of other Negroes, could not feel free openly to acknowledge their relationship. Another example occurred in a social situation when a Negro couple had invited some white friends to a private seaside resort. The Negro hotel owner refused admittance to the whites on the grounds that they had many recreational resources of their own and had no need of utilizing the few belonging to Negroes. Sometimes, it is true, association with whites is highly valued as a means of gaining status, but many Negroes believe that they could never

¹¹ Case illustrations are included in Rose Cooper Thomas, *Mother-Daughter Relationships and Social Behavior*, Social Work Series Number 21 (Washington, D.C.: The Catholic University of America Press, 1955).

¹² Arnold Rose, *The Negro's Morale: Group Identification and Protest* (Minneapolis, Minn.: University of Minnesota Press, 1949), p. 77.

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overcome an ingrained antipathy for a white person with a Southern accent.

Segregation has resulted in many Negroes practicing their own form of Jim Crow isolation in order to be by themselves and relax from the constant strain of the various forms of accommodation. Their purpose may be simply to gain temporary respite or it may be more far-reaching in terms of setting up separate Negro institutions. Frazier has commented as follows: "Some Negro social workers have favored separate agencies to handle the problems of colored people. The Negro's professional interest in segregated schools, hospitals, and welfare agencies is generally accompanied by rationalizations about the peculiar needs of the race; or the exclusion, real or potential, of trained Negroes from employment in non-segregated institutions."¹³

COST OF EQUALITY

Whites and Negroes alike look to the day when segregation will end and this country will no longer have a well-deserved international reputation for poor race relations. The Supreme Court decision has committed all citizens irrevocably. Segregation has had certain by-products, certain special privileges which some Negroes may find it difficult to relinquish. "It is the Negro professional, the business man, and to a less extent, the white collar worker who profit from segregation. These groups in the Negro population enjoy certain advantages because they do not have to compete with whites."¹⁴ The children, too, will be affected. Mildred Faris has observed: "Having won the right to attend school with children of other races, the Negro child must now cope with individual insecurities and individual acceptance or rejection. What was formerly racial rejection has to be dealt with now as rejection of a particular

individual or family."¹⁵ Alexander King has phrased his personal belief as follows:

I suppose this is about as opportune a time as any for me to make clear my attitude on race prejudice. I'm sure I'm completely free from it. I want Negroes and others to get all possible rights of equality because only then will I be able to esteem them, or to loathe them, *individually*, as I do white people. But at this time I'm still compelled to stand a lot of rudeness, boredom and nonsense from some of my darker brothers, simply because some of these specifically offensive individuals happen to belong to an abused and injured minority toward whom I have an unavoidable sense of guilt. I must personally lick up the memory of all the insults, all the humiliations and all the lynchings that their race has suffered, and so I shall never be able to treat them as true equals until all this color iniquity stops, once and for all. You understand?¹⁶

Social workers, trained in correcting inequities and experienced in overcoming social disequilibrium, do understand the enormity of the task ahead. "As the walls of segregation 'come tumbling down,' the Negro will lose all these petty advantages. If this results in the social and psychological deflation of some, it will nevertheless cause Negroes generally to acquire a saner conception of themselves and of their role in American society. Through the same process, white people will come to regard Negroes as human beings like themselves and to make a more realistic appraisal of their personalities and of their work."¹⁷

¹³ Mildred Faris, "Health and Illness: The Dynamics of Family Interaction." Unpublished paper presented at the National Conference of Social Work, San Francisco, 1955.

¹⁴ Alexander King, *Mine Enemy Grows Older* (New York: Simon and Schuster, 1958), p. 190.

¹⁵ Frazier, "Human, All Too Human," *op. cit.*, p. 100.

¹³ Frazier, "Human, All Too Human," *op. cit.*, p. 75.

¹⁴ *Ibid.*, p. 75.

POINTS AND VIEWPOINTS

Reactions and Rebuttals to "A Strike Situation"

Considerable reader reaction was evoked by the article in the April 1960 issue entitled "Problems for a Profession in a Strike Situation," by Helen Rehr. The quantity and quality of this reaction—serious, thoughtful, and highly professional—have been extremely gratifying to the Editorial Board whose members feel that examination of controversial issues is one of the most important contributions the journal can make to the development of the profession. Since a number of readers queried the role of NASW, both nationally and locally, in such a situation, SOCIAL WORK has obtained permission to reprint a communication from the chairman of the national Commission on Personnel Standards and Practices that states its position. This letter is followed by a sampling of the mail received.

TO THE CHAIRMAN OF THE NEW YORK CITY CHAPTER:

At its recent meeting, the Commission on Personnel Standards and Practices considered a letter received from a member of the association who is resident in New York City and who was concerned about the NASW action in reference to the hospital strike. This member said:

Before and during the recent strike of nonprofessional staff at six New York hospitals, the local chapter of the NASW wrote to the directors of these hospitals, to the presidents of the Boards of Trustees, and to several of the local newspapers. The chapter related itself to two broad issues, urging union recognition, and focusing on civil rights for the social workers. The question which was not handled in the letters is an examination

of the implication of what is sound professional conduct for the social worker in this kind of situation. The civil rights issue appears to completely overshadow this question in the statements of the local group.

We believe our association Code of Ethics on this point is clear. Yet in the recent strike situation, the code was interpreted in two lights with variation of conduct by social workers—some workers remaining in the hospital to serve patients and others not being willing to pass the picket line. The chapter's position seems to us to have forced and reinforced a dual interpretation of the code.

We believe it is essential that the association develop a statement which will give basic sound understanding on what is meant in our Code of Ethics in regard to the professional responsibility of the social worker to the client/patient. The issues involved are not indigenous to a particular community but go beyond local areas. Unfortunately this question may well be arising in different parts of the country and direction from the national association is absolutely necessary. The position of the local chapter highlighted what we believe to be a fallacious approach to the problem. We would like to request a review of that position by national and whatever action it is possible to take.

In response to this request the commission sent the member the following letter:

The national Commission on Personnel Standards and Practices considered with interest your letter of November 4, 1959, and related correspondence. As a result of its deliberations, the commission reached the following conclusions:

1. The commission did not believe

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that it would be proper for it to review the position taken by the New York City Chapter without having before it material from the chapter concerning the reasoning upon which the New York City Chapter position rested. The national commission was glad to learn that the New York City Chapter has under active consideration the development of an additional statement concerning this situation.¹ It may well be that this statement will resolve some of the doubts you have concerning apparent omissions in the official policy statement of the chapter.

2. The commission believes that the first point in the Code of Ethics is ambiguous and is subject to varying interpretations by competent and ethical social workers. As you know, the first point in the present Code of Ethics states that the social worker should "regard as his primary obligation the welfare of the persons served, consistent with the common welfare and as related to the agency function and or defined by law." It is easy to understand the way in which certain medical social workers might, during a hospital strike, see the qualifying clause in the quoted statement as justifying a refusal to cross the picket line.

3. Under the jurisdiction of the commission a new Code of Ethics has been developed. If it is approved by the Board of Directors and the Delegate Assembly, it will become binding on all members. Although it does not have official status at this time, I am enclosing a copy so that you can see the way in which the commission has attempted to highlight in an unequivocal fashion the primary obligation to the client or patient.² The commission believes that in a hospital strike the medical social worker must continue to give service to the patients and, if it is appropriate, find avenues for the support of the strikers, short of refusal to continue to give service to the patients. The commission believes that the proposed Code

of Ethics would give social workers seeking guidelines for behavior in a strike situation greater clarity than the present code.

4. Once the new code is in effect, the commission plans to develop a casebook wherein there would be full discussion of some of the ethical issues which social workers face. The commission has resolved that the question of ethical behavior during a hospital strike is of sufficient import to be included as the first case in the casebook and will take action toward this end. The development of a full discussion of such ethical questions as confronted social workers during the New York hospital strike will undoubtedly aid social workers in other communities if they are called upon to deal with a similar situation.

5. The commission believes that the hallmark of the social work profession is its dual concern with social reform and social work practice. These two concerns are, of course, interrelated and supplement and complement each other. Nevertheless, these twin concerns present social workers with ethical choices of a greater complexity than might be found in certain professions that are almost entirely practice oriented. This was certainly the case in the New York hospital strike, where some social workers plainly saw their professional obligation to improve social conditions by supporting the strike as taking precedence over their professional obligation to continue to give service to the sick. Others, like yourself, saw that the primary obligation was to the patient, and other means which did not violate the primary obligation needed to be sought in order to work toward the improvement of social conditions. The commission believes that because of the twin concerns there will continue to be marked differences of opinion among NASW members concerning the proper course of conduct when one is torn between allegiance to the individual served and allegiance to a more general social ideal. Recognition of this problem will not deter us in our efforts to solve it in terms of specific situations, but recogni-

¹ This statement has been completed and is available on request from the New York City Chapter.

² See proposed "Code of Ethics," *NASW News*, Vol. 5, No. 2 (February 1960) p. 5.

tion will help us to be tolerant of difference among colleagues on these matters.

I thought you and your colleagues would find this exchange of correspondence of interest.

HAROLD SILVER
Chairman, National Commission on Personnel Standards and Practices, NASW

THE JOURNAL IS to be commended for publishing the provocative article, "Problems for a Profession in a Strike Situation." Certainly, in this area it has provoked a great deal of discussion. A few reactions:

1. The author describes the primary concerns of the social worker as client care and social welfare. Which is primary is certainly discussable and this debate is certainly implied in a number of recent articles in this journal. But in any event, both are professional concerns. The author's major error is in equating the client care with professionalism and the social welfare concerns with personal need. In this case one may have been more important than another, but both were professional concerns.

A doctor, seeing a number of injured at an accident, does not automatically first treat the one who has been his patient, but rather the one most needing his service. Similarly a social worker seeing a variety of needs—here the needs of the patients and the needs of a group to achieve the right of organization—must decide where his professional service is most needed. Again, even the medical profession may withhold a potential life-giving serum from a given patient for the sake of a controlled experiment in a large group. These decisions are never easy and cannot be separated into professional and personal. The development of social welfare must never be divorced from the professional practice of social work.

2. The steel industry is perhaps more vital to life today than the fire department. Yet society can tolerate a steel strike, but not a firemen's strike, because of immediate danger to life. Similarly, it is no disparagement of the importance of social work serv-

ice to suggest that perhaps doctors and nurses cannot leave the job, even temporarily, while social workers can. This difference was not recognized in the article.

3. The article failed to stress that only the letter from the local NASW offered a positive program for solution of the problem. This should be a source of pride to us and is in the best tradition of social work. In this sense, we alone, of the three professions involved, transcended personal concern.

Certainly had the chapter been able to unify on a suggested course of action, it would have been good. A plan for a skeleton force to handle emergencies, etc., might have been set up. But since there was a question of choosing between professional concerns, it is easy to understand why the chapter could not agree.

4. There was a tone about the article, beyond comparison to other professions in the specific, of "Why can't we be like the others?" It sounded like the stereotype of social work chasing its tail. There are many unique things to our philosophy which will be reflected in our organization and there are any number of ways in which the AMA, for instance, should never be a model for us.

From this distance, no one can say what the individual workers should have done in this case. One can only sympathize with the agony of having to make such a decision. But that agony should be a source of pride to us. I hope the day never comes when social workers will see social responsibility only as responsibility to "my clients," any more than doctors see medical responsibility only as responsibility to "my patients."

DONALD FELDSSTEIN

Jewish Community Center
Brighton, Massachusetts

I AM REFERRING to the article "Problems for a Profession in a Strike Situation" by Helen Rehr. I am concerned with a need for

1. A tighter definition and description of the particular responsibility, role and contribution of a social worker in a medical

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setting, in relation to other disciplines and as a distinct discipline. Social work has derived "many of its emphases from other professions." These have also derived patterns from the social work profession. Yet social work has its particular responsibility and contribution.

2. A clear understanding of "who are our patients." We have said "people." People are among our employed in hospitals engaged in tasks skilled and unskilled in nature. Those of us who work in medical settings have had employees referred to us for services.

3. The enunciation of principles about the responsibility of the social worker who daily in working with individuals sees needs repeated so that it becomes necessary to have these channeled to responsible professional groups in order that action may be taken about them for the good of the general welfare. To this end many of us have sat on committees representative of professional personnel and have through the years interpreted the needs of various groups to our hospital boards, committees, etc. I am concerned that the article would seem to limit the role of the social worker in the area of patient care, which is so dependent upon community resources and community responsibility thus breaking down our contribution toward providing a better society; yet we should be aware that our roles as citizens could be enhanced because of our professional experience. Too, those who have "long-term dedication to social welfare" see thereby better service to individuals and our society—can these be separated? Why courses in community organization in schools of social work and community organizations programs staffed by professional personnel? Are these to be divorced from problems of individuals and those requiring casework services? Do schools present such divorcement or segregation?

The question of our identification with groups which aim to improve their status seems the basic issue here. Where do we

stand when we see men and women who work a full day and receive wages that require supplementation from social agencies; and when they become sick, their problems and those of their families become the more complicated. It is notable that in large measure the salaries of non-affiliated social work agencies have been influenced by the action of agencies which negotiate in collective bargaining. Where is the Golden Rule?

The AMA after long conflicts has announced a number of meetings to be held with representatives of labor to work on some of their joint concerns; the federal government is calling management and labor together apparently for similar reasons. The *Industrial Bulletin* issued by the New York State Department of Labor, April 1960, reports programs of United Automobile Workers with social agencies (p. 81). There are other such programs. How can we separate the individual from our society and philosophize about our interests in "individual dignity and well being." Are we moving forward?

Conflicts can be healthy and creative! How can we bring this about? There are many things to be said—too long for a letter. I suggest therefore that open meetings locally and then perhaps at the national conference should be called to discuss this "provocative article." Following such meetings it is hoped that a declaration of principles would evolve with due consideration given to the interests of management and labor and those of us working in medical settings.

SADIE SHAPIRO

Hospital for Joint Diseases
New York, N. Y.

I WOULD LIKE to congratulate the Editorial Board on the April 1960 issue, which contained a number of provocative articles. As a medical social worker, I was particularly interested in Miss Rehr's "Problems for a Profession in a Strike Situation"; while I couldn't disagree more, I applaud her willingness to take so positive a public

position, in opposition to two schools of social work, the NYC chapter of NASW, and what is at least a growing section of social work opinion.

The fundamental question posed is whether it is possible and true for the profession of social work to say it has two commitments—i.e., for help to the individual and for social change—and can these be complementary, not antagonistic? Miss Rehr's thesis seems to be that our commitment, as professionals, is to the individual alone. To quote, "It is true that the long-term dedication to social welfare which is social work tradition perhaps *contributed to the confusion*" (my emphasis). I would counter to this another quotation, from the April issue. On page 100, Prof. Louis Lowy states that every social worker, in any capacity, "should have a professional commitment to promote social change or reform . . . has to develop an 'emotionalized habit response pattern' which will enable him to see his professional role in broad context . . . see himself as an agent of change in relation to his clients . . . also as an agent of change in relation to the society in which his clients live." I believe Professor Lowy is right, and that to the degree that we confine our professional obligation to the individual, we subvert the profession of social work itself.

Are there times when the exercise of one aspect may impinge on the other? Certainly! Each hour taken for participation in a conference or meeting to discuss the effect of emotional tension on ulcers, or the increase of VD among teen-agers, or any other general question, takes an hour from an individual. It is clear, however, that all professions have decided that it is necessary to discuss and take action on many social questions, even though this takes time from the individual patient.

Thus we must say that the question here is really whether the issues in this strike warranted participation. Certainly, social work interest in substandard wages and working conditions is clear, especially in a

medical setting, where the employee may be the client, and where service to all patients may be affected by poor employee morale. All now welcome the very recently enacted New York State legislation, giving hospital workers \$1 an hour minimum wage and disability benefits. Is not our profession remiss in not having spoken out loudly before?

If one grants all this, then still the question remains of whether strike action or refusal to pass a picket line is professionally permissible. How does one draw the line where we stop in our obligation to change clearly harmful social conditions? Assuming the union had taken all possible steps and still met failure in securing collective bargaining, and assuming that all emergency services for patients were maintained, might not participation in the strike have been meeting our fullest professional obligations?

There are many differences in our field as to what constitutes meeting our obligations—be it to the individual or the field or society. Surely the existence of conflicting opinions does not mean there is no profession or that another view is unprofessional, as implied by Miss Rehr in her quotation, "professional responsibility takes precedence over his personal aims and views." To this, one might again quote Prof. Lowy's article, page 98: "It is understandable that during the period of its professionalization and search for status social work might have avoided a position which would disturb its acceptance by those forces in society which bestow status."

New York, N. Y. FLORENCE WALLERSTEIN

One cannot help but marvel at the inconsistencies, confusion, and stupidity with which a "profession" (social work) handled itself in this situation. How can we as social workers expect other disciplines to respect us if we cannot have self-respect, when we do not even respect or appreciate the very foundation of our profession, namely, our responsibility to the patient, regardless of our personal desires?

Points and Viewpoints

Throughout its history, social work has molded itself after other social disciplines, offering little that is original. Why in this time of test did it not try to develop some new concept in client-employer-(social) worker relationship, instead of following and trusting the policy of related professions of nursing and medicine?

Since this problem may affect social workers other than those in New York City, why did the New York City Chapter, which apparently was very unsure of itself, not refer this problem to the national association? The National Association of Social Work Code of Ethics, quoted by Miss Rehr, certainly appears in direct contrast to the stand taken by the New York City Chapter.

Before we can begin to be accepted as a profession on the level with psychology, nursing, pharmacy, etc., we must act as well as speak professionally.

I am sure the action on the part of the medical social workers at Mt. Sinai Hospital has caused many hospital administrators and hospital boards to re-examine their policy toward their social service departments, and question the professional level of social work.

Since social work has constantly been examining itself through countless committees and subcommittees for a number of years, perhaps some one can tell Miss Rehr and myself, "How professional is the profession of social work?"

Norfolk, Virginia WILLIAM GOLDSMITH

I WOULD LIKE to express my concern about Miss Rehr's article. Her attitude toward social workers who refused to cross the picket line and her criticism of the stand taken by the New York City Chapter of the NASW seem highly questionable to me. I am certain that nobody disagrees that a strike in a hospital setting is an extremely serious and deplorable situation. However, by not developing the factors which led to this unfortunate event, Miss Rehr gives a very one-sided and subjective picture, and she does not see the responsibility of the

social worker in its right context and perspective. For whatever reasons, she hardly mentioned the fact that the union had tried all possible ways to avoid a strike situation and that administration ignored these attempts as well as the efforts of the mayor and other responsible people in the community to find a peaceful solution prior to the strike.

I also cannot go along with Miss Rehr's separation of the responsibilities of the case-worker as a practitioner and principles or ethics required for general social welfare. I think this division (or exclusion of the latter in everyday practice) does not make us more skillful technicians, nor "more professional" social workers.

I furthermore feel that social workers, by refusing to cross the picket line, have helped in the struggle for improving conditions and standards for hospital employees, and thus, in the long run, have hopefully contributed towards securing better services for the patients.

In my opinion, the New York City Chapter has taken a very responsible position and has manifested a real understanding of very basic principles of the social work profession.

HERTA MAYER
Jewish Board of Guardians
New York, N. Y.

I AM QUITE pleased that you published Helen Rehr's article. The writer is certainly clear: she is for a social work profession that combines the virtues of medicine and the dedication of nursing. One need only read about the AMA, which represents the vast majority of physicians in the country, and its vitriolic attack against the Forand Bill to understand the indifference of medicine to the problems of the underprivileged. As for nursing, their dedication has left them in an unenviable position of being understaffed, overworked and horribly underpaid. . . .

Dedication to clients, without consideration of any other factors, is 19th-century philosophy. A profession can only give

uninterrupted qualitative service to clients when the employees who constitute that profession have a sense of security that is related to their rights as well as their responsibilities. We have not yet attained this position and until we do so, social workers will undoubtedly seek means of expressing their grievances in many ways, some of which unfortunately will catch the client between the profession and management.

AARON BECKERMAN

New York, N. Y.

As a UNION representing professional social workers in collective bargaining, we should like to indicate our views on several of the assumptions and implications of Miss Rehr's article in the April 1960 issue of *SOCIAL WORK*. Our professional members have also discussed their concern about the views expressed in this article.

We do not think that Miss Rehr's position reflects the thinking of the profession as a whole. On the contrary, we believe that the position taken by the New York City Chapter of your organization more fully represents the profession's basic orientation.

Historically we are all aware that, from its inception, unionism in social work has adopted the protection and improvement of standards of service to clients as a basic goal. We cannot agree, therefore, with the arbitrary and unrealistic separation of concern for client versus that of the general social welfare.

It must be recognized in any discussion of the social work profession that social workers are not self-employed and cannot by themselves determine the quality and content of their services.

The article referred rather sparsely to many aspects and specifics of the recent hospital situation which developed into strike. Can we forget that the union, Local 1199, for many weeks patiently asked for collective bargaining negotiations only to be met with an adamant refusal? And that intervention by the mayor of New York and the community to achieve peaceful resolution

of the conflict was met by similar intransigence on the part of management? Under these circumstances, who, basically, was responsible for the strike action?

As a union representing professional social workers, we wish to state our conviction that union recognition and collective bargaining are the best instrument to avoid interruption of service to clients as well as the achievement of higher professional standards. We also believe that such a viewpoint is consonant with the best tradition of the social work profession.

HILDA SIFF AND GERALD BEALLOR

Community and Social Agency Employees Union—A.F.L.—C.I.O.

New York, N. Y.

MISS REHR omits what should be the most salient point in any strike situation including this one. Above and beyond the issues raised by a hospital administration which maintained an archaic view of labor-management relations by refusing for weeks to negotiate . . . looms the question of who under the circumstances was the client, or rather who was the client of the social workers at the hospital. Was the client inside or outside the hospital? Every profession in its day-to-day work makes decisions relating to the priorities of which client needs service first and most.

In this case, I submit there were two client groups. The patients inside the hospital, of course, needed help and continuing social work service. The strikers also needed help and social work service. They were a group, suddenly unemployed, who when they worked received salaries patently inadequate to support a single person much less a family. Coming from the lower socioeconomic levels of the city, they needed the professional concern of social workers more than many who are aided every day through the orthodox agencies and services. As Miss Rehr says herself, "Social work is historically and traditionally concerned with the welfare of people, especially the disadvantaged."

Levittown, N. Y. DANIEL ROSENTHAL

Social Work

Delinquent . . . Not Neurotic?

DELINQUENT BEHAVIOR: CULTURE AND THE INDIVIDUAL. By William C. Kvaraceus and Walter B. Miller, *et. al.* Washington, D. C.: The National Education Association of the U.S., 1959. 147 pp. \$1.25.

Delinquent Behavior: Culture and the Individual is a report on the background of juvenile delinquency and its etiology by an interdisciplinary team of social scientists. Sponsored by the National Education Association, the report was written by psychologist William C. Kvaraceus with the close collaboration of a cultural anthropologist, a psychiatrist, a pediatrician, and a criminologist. The report is directed primarily to school personnel with the objective of helping them to understand better the phenomenon of delinquency. It is conceptual and theoretical in nature and is to be followed by a subsequent volume which will offer concrete guidelines to classroom practice.

At the heart of the report is the contention that delinquency, or "norm-violating behavior," is an outgrowth of living in a lower-class community. In other words, delinquency can be identified with "lower-class culture" and particularly with the absorption of the concerns, values, and behavior patterns of that culture. The authors point out that a small percentage of delinquents are found to be emotionally disturbed; the majority are goal-oriented and perform satisfactorily in terms of the standards of their social-class reference group, namely, the lower class. The "focal concerns" which permeate that group include factors such as toughness, seeking excitement, keeping out of trouble, courting

fate or luck, smartness (getting away with it), and autonomy (no one can boss me around). Emotional disturbance, insofar as it is a concomitant of delinquency, is seen as of minor importance and is associated with middle-class youngsters who, when they commit an antisocial act, place themselves directly in conflict with the expectations and practices of their social-class reference group.

Young people are typologically placed in four categories: (a) *Not delinquent and not disturbed*. This includes the great bulk of the youth population. (b) *Delinquent and not disturbed*. This includes 75 percent of all delinquents. The majority of these youngsters (93 percent) originate in lower-class communities and reflect their cultural background. Norm-violating behavior for them may be acceptable or even required by their group and is conducted with little anxiety or guilt feeling. (c) *Delinquent and disturbed*. This includes 25 percent of all delinquents. Emotional conflicts and difficulties in interpersonal relationships in the home and school contribute to norm-violating behavior here. Middle-class youngsters make up 40 percent of delinquents in this category, although they produce only 15 percent of the total delinquent population. (d) *Not delinquent and disturbed*. This group may include the shy and withdrawn, the obsessively conscientious, the self-punishing, the fear-ridden, the enuretic, and the sexually disturbed.

The major conclusion the authors draw from this typology is that the two broad groups, the delinquents and the emotionally disturbed, are not identical. Further, they assert, ". . . the preponderant propor-

tion of our 'delinquent' population consists of essentially 'normal' lower-class youngsters." (Emphasis in the original.)

The term "delinquent" is dismissed as an inappropriate diagnostic concept. Types of delinquent acts vary greatly and often are symptoms of deep underlying social and emotional difficulties. The authors prefer the term "norm-violating behavior" and they state that this term, too, is quite broad. In sketching the dimensions of the delinquent act, the following considerations are offered: the form of the act, its seriousness, its frequency and its relationship to earlier behavior and the child's personality make-up. Further, behavior which may be acceptable in one class or institutional setting may be out of place in another. For example, swearing is highly acceptable in the street-corner gang, is frowned upon in the middle-class group work center, and constitutes a cause for expulsion in the school.

The authors give special stress to the "female-based household" in lower-class culture—one in which there is no father. They deride one-directional theories of causation which attribute all to single factors such as lack of playgrounds or progressive education. Exploitation of delinquency and of youth generally by the adult community in blackboard-jungle films and lurid paperbacks comes in for heavy attack.

From the foregoing it should be clear that this report contains much information of interest to those concerned with the problem of delinquency. It has already created a stir in educational and social welfare circles (see the *New York Times*, Letters to the Editor, May 20 and June 8, 1959), and more controversy rather than less may be anticipated as its impact is further felt. It is a succinctly and lucidly written document which may be quickly digested by those unfamiliar with juvenile delinquency concepts and research, and it is presented in a clear-cut, easily readable fashion. Its main merit is its forceful presentation of the role of culture and social class in an understanding of delinquency. It highlights the fact

that in reality there do exist various social classes in American life and that the living patterns of these classes are associated with differentials in attitudes, values, and behavior. Undemocratic as some people feel such class differences may be, it would be blindness to fail to recognize them and utilize them in understanding and helping the troubled youngster.

A further contribution made by the report is its placing of emotional and psychological factors in a more balanced position within the total delinquency complex. In driving home this extremely useful point, however, the authors tend to swing back too severely on the individual versus the culture continuum. For some time psychiatric concepts have been highly fashionable and have held dominance in the various branches of social work. The authors render a service by counterbalancing this tendency and bringing to the fore concepts of class and culture. In so doing, they tend to overlook their own admonishment to avoid one-directional approaches to the study of delinquency; in the process of rejecting other single-track explanations, they come uncomfortably close to introducing a new one.

While the volume is intended for teachers and other school personnel, and while it confines itself to the realm of social theory, one finds within it a number of implications for social work practice. Several evolving trends in social work receive support here, including (1) the approach taken by the New York City Youth Board and other agencies in centering their efforts in "high delinquency areas," the home of "lower-class culture"; (2) the increasing emphasis on neighborhood planning, including urban renewal, and particularly the involvement of indigenous citizens' groups in improving physical conditions and social standards in low-income communities; (3) the growing recognition that co-operation across professional lines is becoming essential in this field. In this connection the authors urge the schools to render assistance

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"to the delinquent, his parents and other professional workers in the community who are concerned with prevention and control of norm-violating behavior." Concerted community planning emerges here as one of the keys to a more rational and effective way to cope with this problem.

JACK ROTHMAN

*Queens Office of Community Services
New York City Youth Board*

PROGRESS AND PROBLEMS OF COMMUNITY MENTAL HEALTH SERVICES. New York: Milbank Memorial Fund, 1959. 228 pp. \$2.00.

This provocative volume is a report of the 1958 Annual Conference of the Milbank Memorial Fund. The objective of the conference was, in the words of the editors, "to crystallize a number of important issues so that current problems can be tackled in a spirit of co-operation and on the basis of facts thereby raising the level of our community mental health services."

To this end leaders in the field of health, education, and welfare isolated themselves for two days to examine existing programs and to determine the issues that call for resolution. From a discussion of a variety of community mental health programs now being carried on, the participants in the conference agreed that the individual community must determine the nature of its own services. However, they raised a number of questions, the answers to which should be applicable to local programs. Some of these are:

Are community mental health services the responsibility of local government?

How are such services best organized and administered?

How can community mental health services be integrated with state mental hospitals and with other local health and welfare services, and who should initiate this integration?

What educational programs should be

developed to train personnel to administer local mental health programs?

What training should be provided to equip mental health personnel to extend their services beyond their traditional roles?

What is the relatedness between mental health and public health?

While the book has special significance for psychiatric social workers, for the other mental health professions, and for persons engaged in formal public health programs, all social workers will find it profitable and stimulating. The report should challenge the mental health professions to seek ways of extending their services, and others in the health and welfare fields to make discriminating use of the skills of those trained in the mental health field. In order that adequate methods of promoting mental health, preventing mental illness, and treating and rehabilitating the mentally ill be utilized, appropriate functions and skills of the various helping professions must be identified and integrated. Only by experimentation and initiative of all those involved can new and more adequate methods be determined.

The book, a verbatim account of the conference, holds one's interest throughout. In order, however, for the reader to get its full flavor, the reviewer suggests that the appendix, which contains the working papers on which the conference was based, be read in conjunction with the first section of the book.

Despite the stimulating nature of the report, it might have had more breadth had a greater number of state administrators attended the conference. The involvement of state leadership and money in local programs requires intimate knowledge of the problems of local development and the contribution of state agencies toward their solution.

ELIZABETH McDONALD

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YOUTHFUL OFFENDERS AT HIGHFIELDS: An Evaluation of the Effects of the Short-Term Treatment of Delinquent Boys. By H. Ashley Weeks. Ann Arbor: The University of Michigan Press, 1958. 208 pp. \$6.00.

To the worker with "delinquent youth"—an overcrude diagnostic designation—H. Ashley Weeks presents a provocative volume, comparing statistically the results of four months at Highfields, a nonpunitive, open-style group home for about 20 boys, with a somewhat longer exposure of a sample of boys with similar problems to Annandale, a typical youth reformatory. Both settings are in New Jersey. In essence, the data reveal that Highfields is decisively more effective—28 percent more than Annandale. Success was determined by non-occurrence of violation serious enough to require reinstitutionalization. Over 200 boys from each setting were compared during a 12-month period following their release.

The statistical procedures used give every appearance of rigor and accuracy. Tetrachoric correlations between nine background variables and outcome are given and indicate that there was little difference between the distribution of backgrounds of the two samples, strengthening the argument that the Highfields setting was more effective than Annandale. Some question does exist—and is admitted in the body of the write-up—as to whether there was adequate randomizing of the two samples and thus whether two identical populations are being compared. Still every effort was made to describe the two populations carefully, and the reader is quite able to determine that on a gross basis these populations are probably quite comparable. The research is weakest in the attempts to test attitude and personality structure change through the use of devices which are described in a full set of appendices. The test instruments are quite shallow and from a clinical

point of view very unsatisfying. For instance, in hardly any instrument is there any attempt to evaluate unconscious dimensions of psychic functioning, even when the sector being explored could be expected to have important unconscious correlates, *e.g.*, "When you were growing up, who would you say was your mother's favorite child?" followed by five choices, one to be checked.

Although the research described in this book does not attempt to analyze the treatment process at all, the chief treatment method described is a form of group discussion called "guided group interaction" and the inference exists that this is a crucial instrument of change. It is somewhat perturbing in view of the lack of knowledge about what really causes improvement in the boys that the repeated claim of low cost is made. In an era in which underbudgeting is a grave problem in creating programs for disturbed youth, it might be wiser to hold back enthusiastic estimates of low cost until more is known about all the variables involved in the clinical experience.

The book includes separate essays on the Highfields project by Earnest W. Burgess, Richard L. Jenkins, Walter Reckless, G. Howland Shaw, and Wellman J. Warner. Of these Dr. Warner's is an excellent critical appraisal of the total research and Dr. Jenkins' is thought-provoking as to some possible reasons for success. Finally, whatever criticisms this reviewer has made of the volume do not reflect a critical attitude toward the experiment. We desperately need prolific experimentation in residential treatment of youth with serious behavioral problems so let us salute Highfields as a courageous and hopefully permanent step in this direction.

DAVID WINEMAN

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MY NAME IS LEGION. By Alexander H. Leighton. New York: Basic Books, 1959. 452 pp. \$7.50.

It is too bad that Alexander Leighton does not teach the human development and psychiatric courses as well as those in the social sciences in a school of social work. He could also handle a medical information course very adequately and could pinch-hit in most other social work courses. His professional training and experience is solid in the areas of physiology and neurophysiology, medicine, psychiatry, social psychiatry, and social anthropology. On top of all this, he is an artist who can write moving and poetic prose and has produced at least one admirable documentary movie on the Eskimo of St. Lawrence Island. He has had extensive administrative and research experience in the Navy in a Japanese relocation center in World War II and in psychological warfare research. For the past ten years he has administered a large-scale research project in social psychiatry involving the participation of over a hundred researchers from several disciplines.

If *My Name Is Legion* were not part of a series of publications, I would recommend a much longer review of this book. In itself this volume is the first of a three-volume report of a ten-year exploration of the sociocultural context of mental illness in Stirling County in Nova Scotia. It outlines in some detail a theoretical framework and a series of hypotheses or propositions. The data supporting these propositions will be presented in Volumes 2 and 3. Without the supporting data it is difficult to evaluate the theoretical structure, but this structure appears sufficiently plausible and authentic so that one awaits the data eagerly. When these data are available, the three volumes may require a long review and the careful attention of the entire social work profession.

In the meantime, this volume can be recommended to schools of social work and to the profession for several reasons. (1) It presents a new comprehensive theory of

human behavior, including an interesting development of the key concept of sentiments. The theory integrates Dr. Leighton's professional knowledge and experience ranging from physiology to anthropology.

(2) It can be considered a textbook of social psychiatry in that it includes a graphic description of major psychiatric illnesses presented in a sociocultural context. (3) It presents a systematic method for studying the incidence and prevalence of mental illnesses in a sociocultural context. (4) It presents a challenging series of propositions regarding the etiology of psychiatric disorders in the major areas of heredity, psychological processes, and social processes. Here it avoids the concepts of positive mental health, such as those recently presented in Marie Jahoda's book, on the grounds that value-free data for such investigation do not yet exist. (5) Finally, it is very well and at times poetically written. The volume is strongly recommended to the social work audience, with the caution that it will be much more meaningful when the other two data-laden volumes are available.

RAYMOND F. GOULD

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Washington, D. C.*

SOCIAL SERVICE IN HAWAII. By Margaret M. L. Catton. Palo Alto, California: Pacific Books, Publishers, 1959. 308 pp. \$6.00.

This book, the first general history of social agencies in Hawaii, provides rich data previously unavailable. Facts about early organizations in Hawaii were painstakingly obtained and efforts made to assure their authenticity. The content is divided into two parts: the first is a chronicle of selected social agencies in Hawaii, and the second describes the development of medical social services in Honolulu. The book is beautifully illustrated with many photographs of persons and places in Hawaii.

The purpose of Part I is to present brief summarized histories of "casework" agencies since the founding of the first one in 1852. Major attention is given to the chronological description of the origin and changing services of eight private family and child welfare agencies and their predecessors in Honolulu. One chapter describes the development of medical and domiciliary services and one deals with social agencies other than Oahu. In view of the importance of public welfare in Hawaii, the scanty attention given to such programs as public assistance, social insurances, and public child welfare services seems regrettable. Correctional services and social work in the schools are barely mentioned. Purposely excluded from the research were settlements and community centers, youth-serving agencies, and community organization agencies.

Miss Catton's own distinguished career as a medical social worker in Hawaii since 1919 is reflected in the greater detail and integration of facts in Part II. This is a lively written history of medical social work as developed by the Medical Social Service Association of Hawaii of which the author was for many years the executive director. The beginnings of social services in medical settings, the development of standards for the practice of social casework, and the functions of the worker in research, education, and participation in institutional and community activities are described well.

This is a sourcebook of facts that may be useful to social workers and historians interested in making comparative studies of social services among the states or in delineating trends in social work. The book is useful also to social workers generally to help them understand the roots of some of our current agencies, professional practices, and services.

HELEN NORTHEN

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GROUP METHODS IN SUPERVISION AND STAFF DEVELOPMENT. By Arthur C. Abrahamson. New York: Harper & Brothers, 1959. 201 pp. \$3.75.

Part I contains an excellent formulation of concepts and principles pertaining to the use of group methods for supervision and staff development in health and welfare programs. This is a systematic presentation based upon six years of scientific study and testing. Fourteen concepts selected from those germane to the philosophy, theory, and practice of social work are discussed from the view of pertinency to the use of group methods for achieving training objectives.

Part II contains six case studies; five are analyzed as illustrating the conceptual material presented in Part I. The final chapter includes a wire-recorded dialogue of a group conference chosen because it shows the teaching techniques of an active training consultant. This latter case is not analyzed; instead, the author has suggested several questions as a guide for analysis and discussion.

Perhaps it is sufficient to say that all professional staff of social agencies interested in the use of the group method will find this volume helpful reading. Specifically, however, it is a must for agency supervisors and training personnel.

The logical presentation of the author's thesis on appropriate uses of group methods for in-service training and supervision is refreshing and will perhaps stimulate further analysis in this area. For example, the analytical distillation of the definitions of supervision that have emerged over the years will be useful to many who are now engaged in rethinking concepts of supervision in social agencies.

The clean-cut identification of principles useful for leaders as a frame of reference in implementing agency's training objectives, the simply stated material on skills and techniques in teaching, and the annotated case illustrations make up an excellent

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demonstration of how to teach the effective use of group methods in supervision and staff development. Read it and see for yourself!

EVALYN G. WELLER

*Bureau of Public Assistance
Department of Health, Education,
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Washington, D. C.*

THE COST OF MEDICAL CARE. Geneva: International Labour Office, 1959. 156 pp. plus appendices. \$1.50.

According to the Introduction, this ambitious essay in international economic analysis was launched in 1953 as a result of "the widespread apprehension in social security circles at the increase in the cost of medical care." The scope is bold, the statistical techniques are imaginative, and the conclusions should be comforting to those responsible for balancing income and outgo in the medical care programs provided through social insurance in the fourteen foreign countries considered. "The United States is included for comparative purposes despite our general lack of medical care through social insurance."

Most important of these conclusions is the following: expenditures for medical care under social insurance, per insured person and expressed as a percentage of national income per capita or of a selected "reference wage" (the annual wage of an unskilled laborer in the manufacture of machinery other than electrical), remained generally stable during the decade 1945-55. Only in France and Italy did they increase noticeably, and in England there was a marked decline.

These relatively stable national trends raise many provocative questions. Is it purely accidental that national income per capita, wages, and social insurance expenditures for medical care rose at approximately the same rate? Were medical care expenditures in the various countries adequate to

begin with or not? Should present rates be maintained vis-à-vis other claims on national resources, or raised, or lowered?

It was presumably to open up the exploration of such problems that the authors ventured further into the tricky area of international comparisons. One need not pass judgment on the precision of every figure to be struck by the remarkable similarity reported in the ratios of total per capita medical care costs to national income. For the economically advanced nations, in the early fifties, these ratios ranged from a low of 3.67 in Denmark to a high of 4.56 in New Zealand. Included were countries like England, where 95 percent of the total costs were met through the National Health Service; Denmark, where only 27 percent was met by the national health insurance scheme; and the U.S., where there is no such scheme.

How provocative can a bare statistical report be! Are there self-limiting factors in the demand for medical care which transcend cultural differences and the widely varying methods of distribution? Are there self-limiting factors in the price which the vendors can command?

Again our curiosity is whetted but unsatisfied. The report does not even suggest the answers. But if it arouses interest in additional research along these lines and an appreciation of the many problems involved in the organization and financing of medical care, which transcend national boundaries, it will have more than justified the prodigious amount of work by the authors and the considerable effort demanded of American readers.

ANNE R. SOMERS

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NOTE TO READERS: If you move, be sure to send your change of address on a postcard to Membership Records, NASW. Do *not*—repeat, *not*—send temporary changes or summer addresses.

RELEASED MENTAL PATIENTS ON TRANQUILIZING DRUGS AND THE PUBLIC HEALTH NURSE. By Ida Gelber, Ed.D., R.N. New York: New York University Press, 1959. 139 pp. \$3.00.

This book is a nursing research monograph, based upon a study identifying the needs of released mental patients on tranquilizing drugs, correlating these needs with public health nursing functions, and exploring whether public health nursing can play a significant role in follow-up programs for convalescent psychiatric patients. At this time, the book would probably be of greatest interest to social workers practicing in mental hospital settings, after-care programs and follow-up clinics.

The monumental increase in the number of patients being treated with chemotherapy and then discharged is creating an imperative need for increased professional personnel. Dr. Gelber makes the point that the figure of the public health nurse in both rural and urban areas is a familiar one, and that her services are available.

The data presented about needs of patients are derived from a survey of the literature, a questionnaire answered by mental hospital authorities in eighteen states, and an analysis of the records of 100 released mental patients on tranquilizing drugs. Forty-eight needs are identified, many of which are closely related to the emotional aspects of the family climate, of employment, or of social and recreational outlets, as well as more tangible needs such as those associated with living arrangements, finances, and so on.

The functions of the public health nurse (44 in number) as outlined by the American Nurse Association, Public Health Nursing Section, are presented. Of these, 28 are identified as appropriate for meeting the needs previously noted. Some of these functions are those historically associated, at least in the layman's mind, with public health nursing (for example: "Gives prescribed treatments, teaches, and supervises others who give treatment"). Other func-

tions however sound remarkably like those of social workers, for example: "Guides families toward self-help in recognition and solution of physical, emotional and environmental health problems"; or, "Helps individuals to accept and adjust positively to physical, mental, and social limitation"; or, "Studies environment to identify elements conducive to emotional strain. When possible, effects changes in environment to eliminate or modify hazards." This is not to say that some one other than a trained social worker cannot, or should not, perform these functions, particularly if good supervision of a teaching-enabling type and expert consultation are available. However, the effectiveness with which these and similar functions are carried out necessarily rests upon the nature and extent of the individual's training. The qualifications for public health nursing read in part, "... sequential professional content, including psychiatric education and experience." Dr. Gelber also speaks of the importance of in-service training for nurses whose education antedates the present psychiatric requirement.

While it is true that psychiatric information provides an essential base for all work with psychiatric patients, it does not, in and of itself alone, provide students from any profession with complete equipment for helping people whose problems are emotionally charged. Guiding, helping, or modifying, in order to be truly effective—and as differentiated from more superficial activities such as urging or encouraging—are long, complex, and subtle processes. The skills necessary to bring about change rest not only upon various kinds of academic knowledge, but also upon an understanding of and an ability to use relationship as a therapeutic tool and upon a large measure of cultivated self-awareness. Knowledge, attitudes, and skills requisite to the helping process are the fruit of fairly long, and sometimes arduous training regimes regardless of the professional discipline under whose aegis such training may occur.

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It should be recognized, however, that this monograph is not designed to describe the methods public health nurses would employ in carrying out their functions, nor yet to prognosticate what measure of success their work might be expected to produce. The conclusion reached by the author is simply that the affirmed functions of public health nursing are appropriate in meeting the needs of discharged mental patients on tranquilizing drugs.

Over the years, public health nurses in their work with the physically ill have certainly encountered and undoubtedly worked with patients and family members who have been mentally disturbed, yet a formalized extension of their work to include service to discharged psychiatric patients is still relatively new. Further study of how their functions can be adapted to the mental patient is indicated. As team members willing to extend their services and willing to evaluate both potential limitations and contributions, they can indeed be viewed as welcome allies.

M. GENEVIEVE SLEAR

Psychiatric Social Services

Wayne County General Hospital and
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A NEIGHBORHOOD FINDS ITSELF. By Julia Abrahamson. New York: Harper & Brothers, 1959. 370 pp. \$5.00.

A Neighborhood Finds Itself is delightfully written, with both spirit and practicality. Mrs. Abrahamson has been able to catch the high excitement and sense of adventure inherent in any good piece of community organization and to make it very human and personal. She has done a careful job in assessing the successes and pointing out the failures as well as the back-breaking work inherent in pulling together neighborhood forces for united action.

The story is that of a deteriorating neighborhood on the South Side of Chicago called Hyde Park-Kenwood and what happened after forty residents got together to

decide what they could do to stop not only physical decay but a growing hostility toward newcomers. Negroes were moving into what had been largely a white upper- and middle-class neighborhood. Although many of the newcomers were of the same professional and economic group as the older residents, real estate interests were panicking home owners, and overcrowding and deterioration had set in.

This pattern is a familiar one across the country today, and it is fortunate that some of the answers are becoming more familiar as neighborhoods are girding themselves to fight the "battle of the slums" on new fronts. This particular neighborhood did have, as Mrs. Abrahamson says, an unusually large proportion of highly skilled professionals and a small proportion of very low-income and problem families. The distinguished roster of people involved makes one aware of this. However, the pattern of initiation by an ardent few—the devoted and tireless volunteer effort involved in spreading the idea and the responsibility—the first staff member, the first small office and the second-hand mimeograph machine—are all there in their familiar sequence.

At the time of writing the staff was eleven and the budget \$60,000. I mention this because there seems to be a myth abroad that while councils of social agencies or other forms of community organization take money and skill, the nearer you get to the neighborhood and so-called "grass roots" organization the nearer you should be to complete self-support.

Mrs. Abrahamson also makes very clear that to succeed even in the smaller immediate objectives, let alone real neighborhood replanning, the lines from the neighborhood to City Hall must be kept cleared all the way. She has lots of interesting things to say on this salient point as well as the many others with which she deals so skillfully.

HELEN HALL

Henry Street Settlement
New York, N. Y.

TRIBUTE FROM A TEACHER

I read with much interest and enlightenment Miss Bemmels' article entitled "Seven Fighting Families" in the January 1960 edition of your magazine.

As a parent and educator I feel that the public needs more of this type of article for a clear and deep understanding of the wonderful work our social workers are doing today.

HELEN K. MACGREGOR

*South Ozone Park
Long Island, New York*

IT PAYS TO READ THE JOURNAL

If you need any testimonials, you may quote me: "It pays to read SOCIAL WORK!" The announcement about the Fulbright program for social workers in the July 1959 issue inspired me to make application for a grant with the happy result that I shall be in London next year studying the juvenile courts and their allied services. So thanks to you for printing that announcement.

JEAN RUBIN

*Community Service Society
Bureau of Public Affairs
New York, N. Y.*

GROUP WORK SUPERVISION

I was very happy to see the article on group work supervision by Irving Miller (January 1960) and I think that it points up the fact that the journal is trying to publish as many diverse opinions in all areas of social work as possible.

I would agree with almost everything Professor Miller said and I think that his views are important since they come from one from the academic side of the profes-

sion. We in social work talk about standards as though they were magical things which would automatically give us some kind of professional status. These magic standards have become fetishes and we tend to automatically feel that if a particular agency follows certain practices it is more professional than other agencies. However, the one thing we forget is to sometime evaluate exactly what we are doing when we follow these standards. I think Professor Miller is correct in pointing out the danger of this kind of thing. For example, we should honestly ask, does seeing the leader of a group once a week make us professional or is the content of the supervisory conference as important as the automatic holding of the conference? Too many agencies automatically hold conferences without really discussing and thinking out the goals of such conferences.

Going from Professor Miller's article to another subject, I would like to point out that our agency is attempting to do more qualitative and investigatory work in the whole area of supervision. Dr. Daniel Thursz of our national staff has just finished what I believe is a monumental study entitled *Volunteer Group Advisers in a National Social Group Work Agency*. The work is Dr. Thursz's doctoral dissertation and it can be obtained from the Catholic University of America press. EARL YAILLEN
*Director, Michigan Region
B'nai B'rith Youth Organization
Detroit, Michigan*

Irving Miller's article, "Distinctive Characteristics of Supervision in Group Work," in the January 1960 issue is one of the few available on supervision in group work. The basic propositions which he has stated certainly are provocative and provide a good basis for examination by the field. Before doing this, it is interesting to note that Mr.

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Miller collaborated with Mitchell Ginsberg in the *Group Work Papers* 1957 to write an article entitled: "Problem of Conformity As Faced by the Professional Worker." In this article, the authors state that one of the sources of conformity is the "content and methods of learning and teaching group work."

In relation to this point, the authors say that many of the teaching methods "inhibit creativity and initiative and tend to induce patterned responses rather than genuine learning." The examples that were given of this included the emphasis upon the importance of relationship to the point that it appears to be the purpose of supervision rather than upon the quality of service that the worker is giving, and the insistence upon the pattern of "being positive, sharing feelings, and working through resistances, presumed or otherwise." Other concerns which were mentioned were around the probing into the motivations of workers and the problem of dependency which may be created by supervision. While these charges appear valid to some extent, one may wonder if both articles don't contain elements of rebellion against conformity themselves, since no mention is made of other authors' discussions of these points and no mention is made of the individual differences which in themselves determine the validity of the charges given.

Every point which Mr. Miller made in the article could be substantiated by literature already existing in the field. For example, Mr. Miller charges that recordings are often filed "into unproductive and unread obscurity." While this may be true in practice, other authors such as Clara Kaiser as quoted in Margaret Williamson's book, *Supervision, Principles and Methods*, states that "records are only important as they serve as instruments to do a better job with the people with whom we are working."

While this article raises some interesting questions, at times Mr. Miller seems to be using extreme cases in the field to make

these points. Certainly this is valuable in terms of actual practice in the field, but major differences in terms of group work theory couldn't be ascertained.

Conformity obviously has its disadvantages, but question can also be raised with nonconformity for the sake of nonconformity; and the line between this and critical appraisal is sometimes a confusing one. The value of this article is that it does provoke critical appraisal and through this, hopefully, the theory of supervision in group work can be clarified.

SHIRLEY McCUNE

*Student, School of Social Work
University of Denver
Denver, Colorado*

CENTRALIZED PLANNING STRUCTURES

I am writing in response to the article in the April 1960 issue of *SOCIAL WORK*, "The New Look in Community Planning" by Violet Sieder. I want to express the appreciation of many persons both to the author and to the journal for presenting this substantial and well-organized article. It was particularly appreciated at this time because of its cogent organization of the fundamental questions that should be weighed in the many communities where the community planning structure has been or is about to be altered. The implications of the highly centralized and nonrepresentative structures which have been created are frequently overlooked or only partially presented as compared with the arguments for efficiency and streamlining.

I do not believe that the material which Miss Sieder so ably presents has been as well presented in print elsewhere. Therefore I hope that you may be able to call to the further attention of your readers that they may, with permission, make reprints of the Sieder article. I believe that such reprints can have substantial value as an educational tool within both lay and professional circles.

It is significant of the continuing development of the weight and importance of

the NASW journal that an article of this import is only one contribution of your April number.

I am sure that I speak for many of the silent members of NASW in appreciation of the major strengthening of our professional publication in these past few years.

PERRY B. HALL

*Family and Childrens Service
Pittsburgh, Pennsylvania*

ETHICS IN CALIFORNIA AND NEW YORK

Please convey my thanks to the author [Helen Rehr, April 1960] for her brilliant statement of the moral responsibility of social workers. Clearly we must accept the obligations of a profession if we aspire to the privileges of a profession.

I wish to emphasize her suggestion that the duty to behave professionally does not interfere with the duty to take a stand on social issues. It seems to me that sober, statesmanlike behavior is most likely to win the respectful attention of our fellow citizens.

Confusion about ethical principles is not limited to strikes in New York. In California we need to learn how to differ with each other in a dignified and honorable manner. Perhaps the best way to improve the public image of the social worker is to consider our public actions as social workers!

Finally, thanks to you for publishing this important paper.

JEANNE CAUGHLAN

San Mateo, California

RESEARCH UTILITY

There is room for argument about Gordon Manser's statement (April 1960) that "The test of the appropriateness of research for a planning council lies in the utility of the results for operating agencies. In other words, there must be effective consumer demand for the product of the council's research." All sorts of interesting questions arise, such as how can demand for a product

be determined in advance? Should any distinction be made between that aspect of research utility which lies in the person who lacks knowledge and the quality of the knowledge available? Manser's test might do much to stifle creativity and initiative on the part of the researcher, but it is doubtful if it would be useful in community planning.

I would prefer the test of whether the findings represent a solid addition to what is known about the community and community planning. If such information is regarded as lacking in utility, it's time to investigate the staffing aspect of the planning council.

DONALD A. TRAUGER

Westwood, New Jersey

COMPETITION WITH MR. ANTHONY

The April 1960 number of the journal seems to me to have the greatest number of excellent articles that have appeared in some time. When one becomes discouraged about the progress being made in the social work field it is indeed heartening to read such material.

One that particularly pleased me was "Radio: A Medium for the Presentation of Social Work." At last someone has had the courage to compete with the Mr. Anthony's and other advisers to the public, whom, as was pointed out in the article, we have criticized but have done nothing ourselves. A few uninteresting, stereotyped programs have been tried in various places with our usual caution and fear of saying anything. Proof of their lack of interest to the listening audience was the early morning or very late evening hour assigned to them by the radio station.

With the success of the venture in Cleveland, hopefully other social workers will attempt similar programs instead of complaining about the lay population which fails to support them because they just don't know what we do.

G. W. SCHMIDT

New York, N. Y.

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